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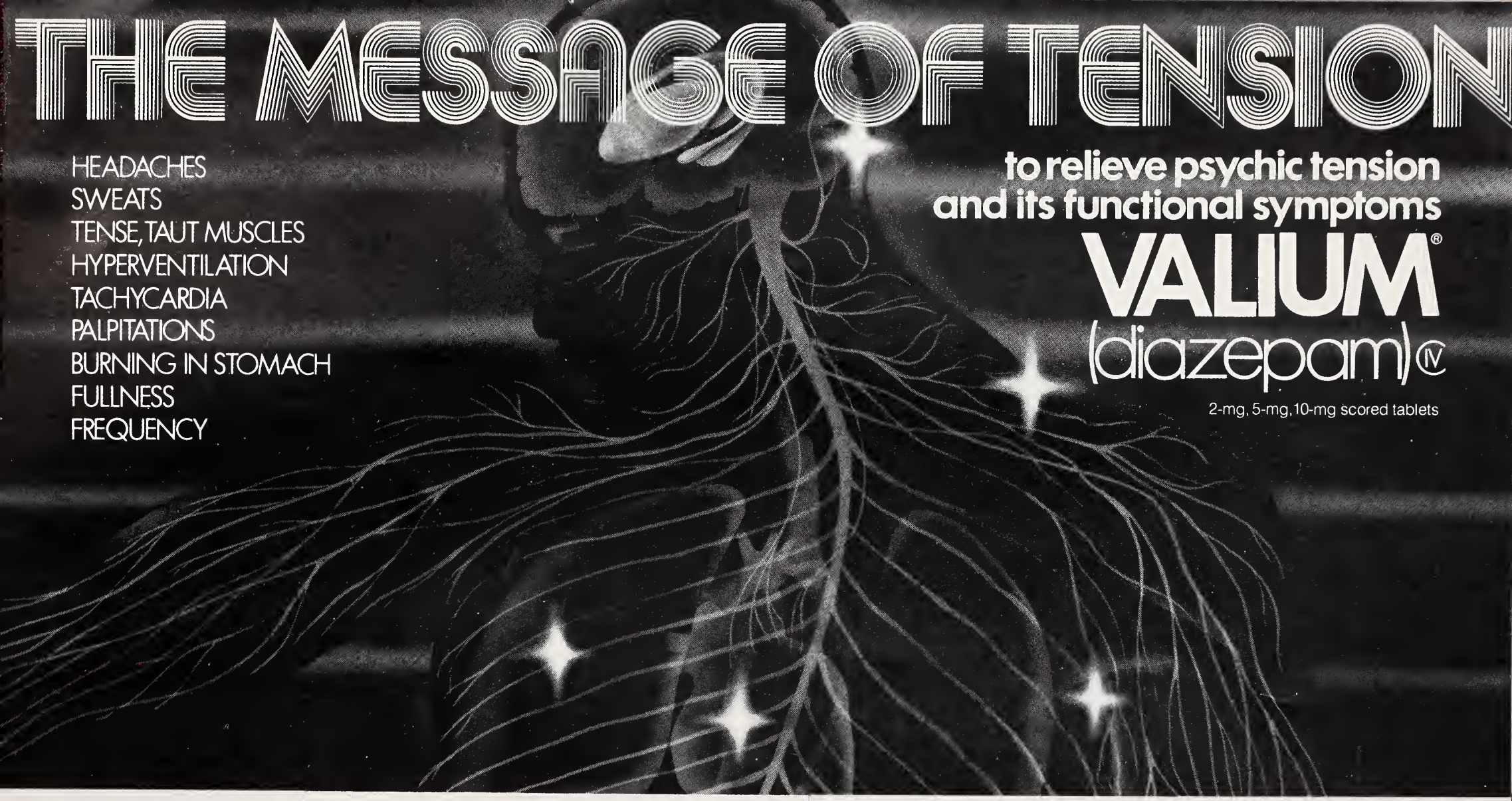
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The Georgia General Assembly convenes on January 8...

SPECIALTIES: Divided we fail, but under MAG, united we prevail

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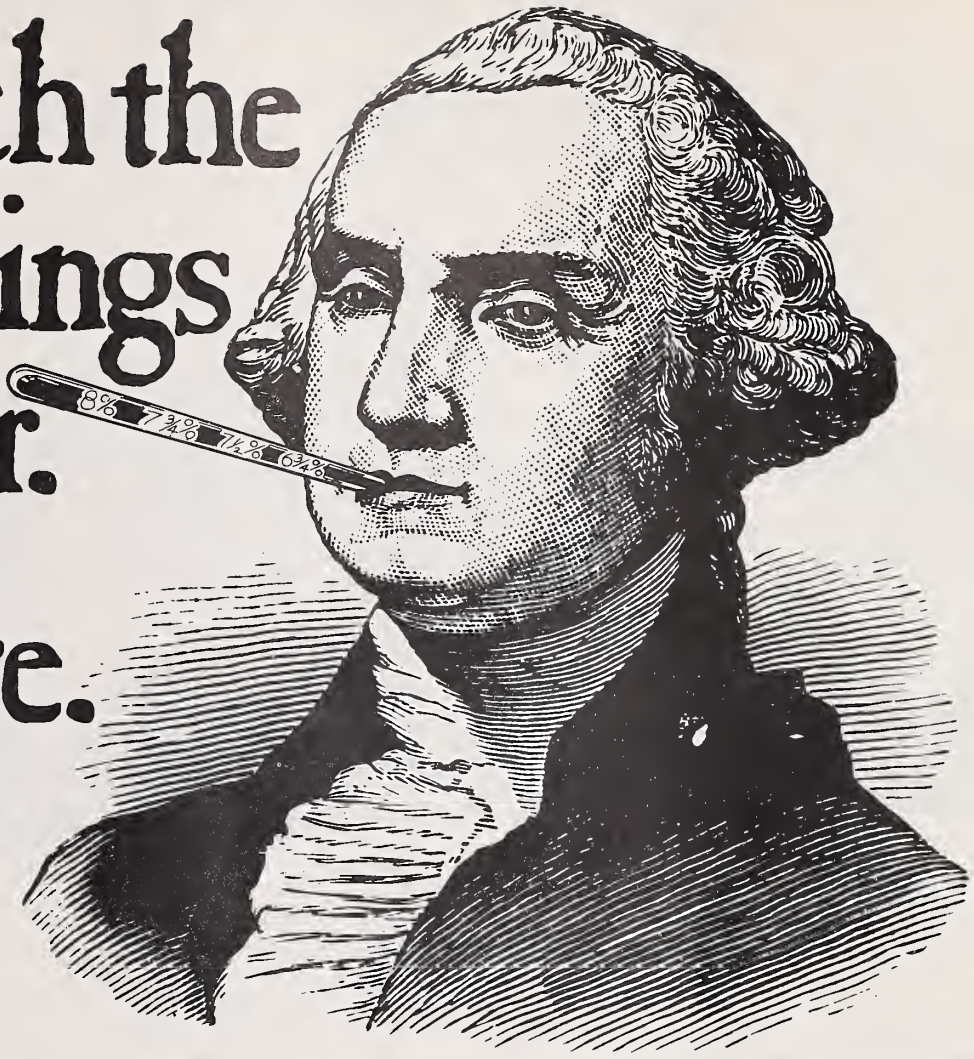
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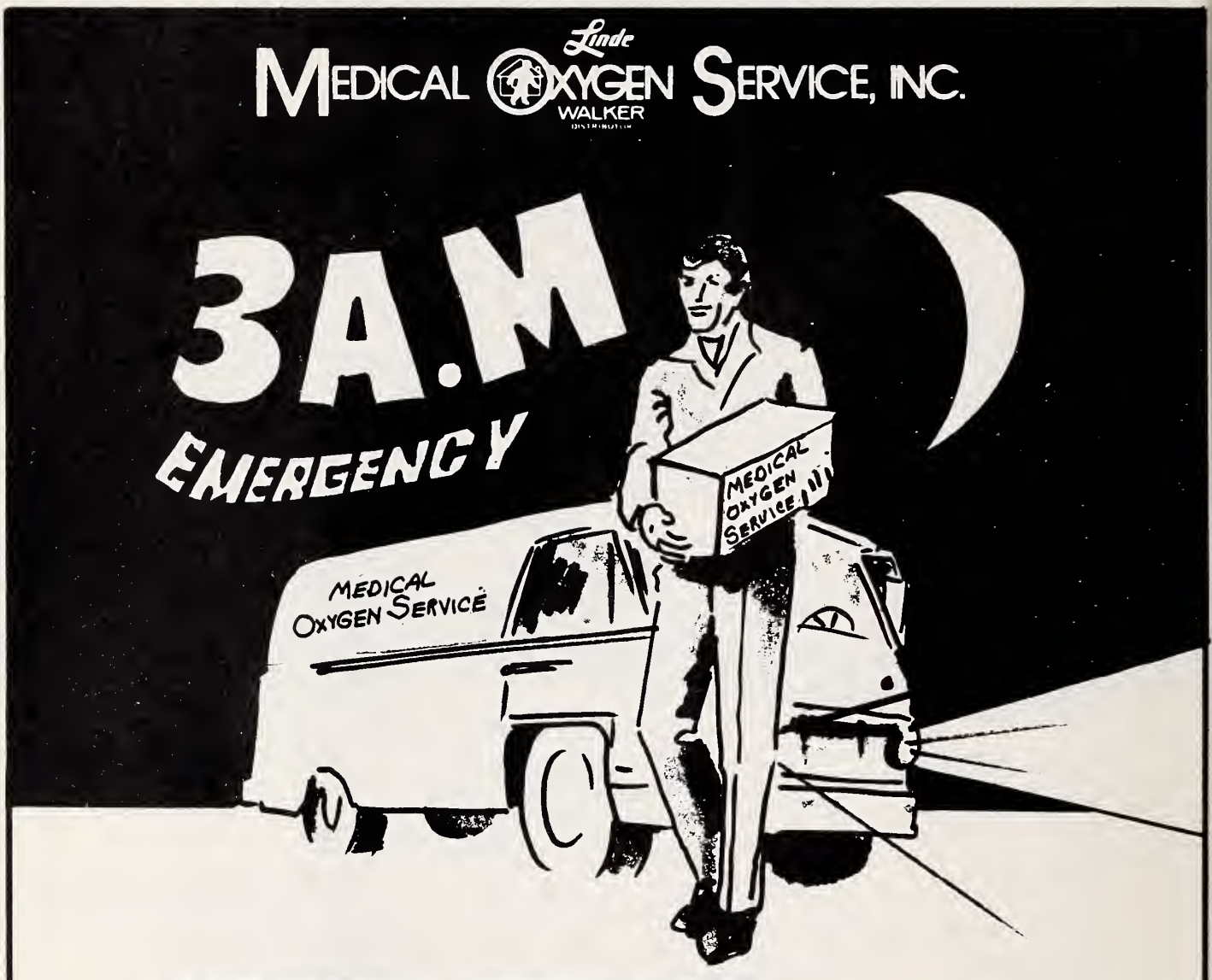
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MEDICAL MEETING CALENDAR

JANUARY

27—*Macon;* **FAMILY PRACTICE CLINIC OAY;** Contact: Don D. Purdy, M.D., Director, Family Practice Office, Medical Center of Central Georgia, 784 Spring St., Macon 31201. PH: 912/745-5464.

30—*Atlanta;* **TEAM BUILOING—A BETTER WAY TO SUPERVISE (WORKSHOP FOR OFFICE MANAGERS);** Contact: Sue McAvoy, MAG, 938 Peachtree St., N.E., Atlanta 30309. PH: 404/876-7535.

31—February 1—*Atlanta;* **STARTING YOUR PRACTICE (WORKSHOP FOR RESIOENTS);** Category 1 credit; Contact: Sue McAvoy, MAG, 938 Peachtree St., N.E., Atlanta 30309. PH: 404/876-7535.

FEBRUARY

4-10—*Charleston, SC;* **TENTH ANNUAL FAMILY PRACTICE REFRESHER COURSE;** Contact: Medical University of South Carolina, 171 Ashley Ave., Charleston, SC 29403.

5-7—*Atlanta;* **ANNUAL MATERNAL-FETAL POSTGRAOUATE CONFERENCE;** Category 1 credit; Contact: Associate Dean for CME, 69 Butler St., S.E., Atlanta 30303. PH: 404/588-3534.

8-9—*Augusta;* **CLINICAL PSYCHIATRY;** Contact: Division of Continuing Education, Medical College of Georgia, Augusta 30901. PH: 404/828-3967.

14-15—*Nashville, TN;* **FRONTIERS IN MEDICAL ETHICS: APPLICATIONS IN A MEOICAL SETTING;** Category 1 credit; Contact: Virginia Abernethy, Ph.D., Vanderbilt University School of Medicine, Nashville, TN 37203. PH: 615/322-2716.

19-23—*Durham, NC;* **MICROVASCULAR SURGERY WORKSHOP;** Contact: Malcolm H. Rourk, Jr., M.D., Continuing Medical Education; Duke University Medical Center; Durham, NC 27710.

24-25—*Birmingham, AL;* **ISSUES AND ANSWERS IN ANESTHETIC PRACTICE;** Contact: University of Alabama School of Medicine, University Station, Birmingham, AL 35294.

MARCH

1-2—*Atlanta;* **COMPLETE MANAGEMENT OF THE LONG-TERM HEMODIALYSIS PATIENT;** Category 1 credit; Contact: Kathryn A. Hoffman, M.D., Center for Rehabilitation Medicine, 1441 Clifton Rd., N.E., Atlanta 30322. PH: 404/329-5507.

1-3—*Gainesville, FL;* **SIXTH ANNUAL TOPICS IN UROLOGY;** Category 1 credit; Contact: Bill Rockwood, University of Florida College of Medicine, Box J-233, J. Hillis Miller Health Center, Gainesville, FL 32610.

3-10—*Snowmass, CO;* **FOURTH ANNUAL SNOW JOB IN GYNECOLOGY ANO OBSTETRICS;** Category 1 credit; Contact: Associate Dean for CME; 69 Butler St., S.E., Atlanta 30303. PH: 404/588-3534.

5-8—*Atlanta;* **18TH NATIONAL CONFERENCE ON THE OETECTION AND TREATMENT OF BREAST CANCER;** Category 1 credit; Contact: American College of Radiology, 6900 Wisconsin Ave., Chevy Chase, MD 20015. PH: 301/654-6900.

6-9—*Tamarron Ski Resort, CO;* **EMERGENCY MEDICINE;** Category 1 credit; Contact: Division of Continuing Education, Medical College of Georgia, Augusta 30901. PH: 404/828-3967.

8-10—*Atlanta;* **TRANSCUTANEOUS ELECTRICAL NERVE STIMULATION: PRINCIPLES ANO APPLICATIONS FOR THE CLINICIAN;** Category 1 credit; Contact: Steven L. Wolf, Ph.D., Center for Rehabilitation Medicine; 1441 Clifton Rd., N.E., Atlanta 30322.

9-10—*Winston-Salem, NC;* **FRANK R. LOCK SYMPOSIUM IN OBSTETRICS ANO GYNECOLOGY;** Contact: Emery C. Miller, M.D., Associate Dean for CME, Bowman Gray School of Medicine, Winston-Salem, NC 27103.

9-11—*Lake Buena Vista, FL;* **CARDIOLOGY AT WALT OISNEY WORLO;** Contact: American Heart Association, Central Florida Chapter, Box 6665, Orlando, FL 32853.

11-14—*Atlanta;* **ATLANTA GRAOUATE MEDICAL ASSEMBLY;** Category 1 credit; Contact: Winnie Hopkins, 875 West Peachtree St., N.E., Atlanta 30309. PH: 404/881-6128.

13—*Knoxville, TN;* **NEW OEVELOPMENTS IN FAMILY PRACTICE AND EMERGENCY MEOICINE;** Contact: Knoxville Academy of Medicine, 422 West Cumberland Ave., Knoxville, TN 37902.

14—*Greenville, NC;* **RECENT ADVANCES IN SURGICAL CARE;** Category 1 credit; Contact: F. M. Simmons Patterson, M.D., Assistant Dean for CME, East Carolina University School of Medicine, Greenville, NC 27834.

15-16—*Augusta;* **REPROOUCTIVE ENOOCRINOLOGY;** Contact: Division of Continuing Education, Medical College of Georgia, Augusta 30901. PH: 404/828-3967.

15-17—*Atlanta;* **ANNUAL SYMPOSIUM ON SURGERY OF THE HAND: UPOATE IN CURRENT CONCEPTS OF HAND MANAGEMENT;** Category 1 credit; Contact: Associate Dean for CME, 69 Butler St., S.E., Atlanta 30303. PH: 404/588-3534.

18-22—*Atlanta;* **MEETING OF SOUTHEASTERN SURGICAL CONGRESS;** Contact: A. H. Letton, M.D., 315 Boulevard, N.E., Ste. 500, Atlanta 30312.

19-21—*Augusta;* **NEUROLOGIC OISOROERS;** Contact: Division of Continuing Education, Medical College of Georgia, Augusta 30901. PH: 404/828-3967.

23-25—*Atlanta;* **FOURTH ANNUAL OOGWOOO CONFERENCE;** Contact: Ronald Peyton, Scottish Rite Hospital, 1001 Johnson Ferry Rd., N.E., Atlanta 30342. PH: 404/256-5252.

24—*Atlanta;* **MICHAEL HOKE-HIRAM KITE LECTURE PROGRAM: A FULL OAY OF CHILOREN'S ORTHOPEOICS;** Contact: W. W. Lovell, M.D., Scottish Rite Hospital, 1001 Johnson Ferry Rd., N.E., Atlanta 30342. PH: 404/256-5252.

25-28—*Atlanta;* **FIFTH ANNUAL MEETING, AMERICAN SPINAL INJURY ASSOCIATION;** Contact: David Apple, Jr., M.D., 3280 Howell Mill Rd., N.W., Atlanta 30327. PH: 404/352-2234.

26-28—*Jekyll Island;* **SELECTED TOPICS IN OPHTHALMOLOGY;** Contact: Division of Continuing Education, Medical College of Georgia, Augusta 30901. PH: 404/828-3967.

29-30—*Atlanta;* **THE TREATMENT OF ARTHRITIS — UPDATE;** Category 1 credit; Contact: Associate Dean for CME; 69 Butler St., S.E., Atlanta 30303. PH: 404/588-3534.

29-30—*Atlanta;* **MANAGEMENT OF FIRE SAFETY IN HOSPITALS WITH EMPHASIS ON NEEOS OF THE HANOICAPPED;** Contact: Department of Rehabilitation Medicine, 1441 Clifton Rd., N.E., Atlanta 30322. PH: 404/329-5507.

For additional information on these and other meetings, contact MAG, Division of Education 404/876-7535



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A Potpourri of Legislation Slated for 1979-80

JAMES A. KAUFMANN, M.D., *and* RUSTY KIDD, *Atlanta**

THE 1979-80 GEORGIA GENERAL ASSEMBLY convenes Monday, January 8, at 10:00 a.m. During this session the first year of a 2-year term, the Legislature will meet through late March. Approximately 3,000 bills and resolutions will be introduced which could be acted on by mid-March. The topics of these bills and resolutions range from tax reform, child abuse, education, and restructuring state government to dealing with Georgia's fire ants, proclaiming certain days as holidays, appropriations as to where state funds should be spent, etc. It is during this time that MAG anticipates the introduction of a minimum of 50 pieces of legislation dealing with the health care delivery system.

It is the responsibility of the MAG Legislative Committee to screen each bill introduced into the General Assembly and to isolate those dealing with the health care delivery system. The Committee then reports to the MAG Executive Committee, the MAG Board of Directors, and the MAG membership as to the content of this legislation. We also assess what effect said legislation would have on the health care delivery system.

After isolating those bills of primary concern, the Legislative Committee gets as much input as possible from the respective specialty societies with which the legislation is directly concerned. This *in no way* makes this legislation of primary concern *only* to this particular specialty society.

The Legislative Committee then arranges for speakers to testify before the committee meetings in both the House and the Senate regarding this legislation. In some cases, we support the legislation entirely, and in some cases, we oppose the legislation. In most cases, we suggest amendments that would favorably change the legislation so as to insure the delivery of high-quality medical care.

Listed below are a number of bills which are sure to be introduced early in the 1979 session and some which are likely to be introduced. MAG has a position on some of these, and it is indicated where applicable.

1. **Define physician as only those licensed under Georgia Code Chapter 84-9, M.D.'s and Osteopaths.** MAG supports this and seeks a sponsor.

At this time, it is unclear and not specifically defined in Georgia law as to what constitutes a physician. We feel this would greatly simplify the lack of communication on the part of insurance companies, consumers, etc., if a definition of this type were enacted.

2. **Medical Examiner's Fees.** MAG supports.

This legislation would increase the medical examiner's fees from $35 to $50 in cases where dissection of the body is required; from $110 to $150 for a partial post-mortem examination and autopsy; and from $150 to $200 for a complete post-mortem examination and autopsy. The fee in each case is to be paid from funds of the county in which the examination was performed.

* Dr. Kaufmann is Chairman of the MAG Legislative Committee. His address is 950 W. Peachtree St., NE, Atlanta, GA 30309. Rusty Kidd is Director of Legislative Activities of MAG. His address is 938 Peachtree St., NE, Atlanta, GA 30309.

3. **Non-Georgia Resident and Reciprocity M.D.'s.** MAG supports this and seeks a sponsor.

Currently, there are approximately 7,000 M.D.'s licensed to practice medicine in Georgia that do not live in Georgia. These individuals can move into Georgia and set up a practice without the Composite State Board of Medical Examiners knowing. MAG proposes an amendment to the Medical Practice Act by statute or rules and regulations requiring these physicians to inform the Composite State Board of Medical Examiners at least 30 days prior to their opening a practice in Georgia as to their proposed locale and type of practice.

4. **Balancing the Federal Budget.** MAG supports this and seeks a sponsor.

The MAG Board of Directors has asked the Legislative Committee to seek passage of a resolution in the Georgia General Assembly asking Congress to balance the federal budget.

5. **Resolution Asking for a Constitutional Convention for the Purpose of Balancing the Federal Budget.** MAG supports this and seeks a sponsor.

The MAG House of Delegates requested the Legislative Committee to seek passage of a resolution in the Georgia General Assembly asking for a Constitutional Convention for the purpose of balancing the federal budget.

6. **Health Maintenance Organizations (HMO).**

MAG does not oppose HMO legislation, which includes about 16 principles arrived at and approved by the MAG Board of Directors.

7. **Optometric Use of Drugs.** MAG opposes.

Once again, legislation will be introduced to broaden the scope of those persons who are seeking to practice medicine yet do not want to go to medical school. Under this particular bill, optometrists are seeking to be able to use diagnostic and possibly therapeutic drugs on their patients. It is our contention that they have no adequate training regarding the use of, complications of, and diagnostic ability of such drugs.

8. **Chiropractic Insurance.** MAG opposes mandatory chiropractic insurance.

The Chiropractic Association plans to introduce legislation to require all accident and health insurance policies to mandatorily include services of chiropractors. MAG believes this is a breach of contract to mandate said coverage for chiropractic services.

9. **Statewide Voluntary Catastrophic Health Insurance.** MAG supports.

This proposal, endorsed by the MAG House of Delegates in 1978, and also endorsed by the National Association of Insurance Commissioners, would address those 3% of Georgians who are not adequately covered by some form of insurance, be it private or Medicare/Medicaid. We feel this is a better alternative for Georgians rather than to wait for a federally mandated program.

10. **Psychiatric Insurance.** MAG supports this and seeks a sponsor.

MAG is in favor of providing parity for mental illness as compared to physical illness under private and group insurance contracts.

11. **Indigent Care Legislation.** MAG supports.

MAG supports legislation which would require counties in which indigent patients reside to reimburse another county for the health care services rendered to said indigent patient. This would greatly assist regional public hospitals such as Grady, Richmond County, Bibb County, Dougherty County, etc.

12. **Professional Liability — Minors.** MAG supports.

MAG endorses legislation which would provide for a statute of limitations for those physicians treating persons under the age of 18.

13. **Family Practice Residency Programs.** MAG supports.

Continued funding of family practice residency programs involves the budgetary and appropriations committees of both the House and the Senate which MAG will be contacting for support of said programs.

14. **Certificate of Need.**

MAG will not oppose legislation which includes *only* the minimum concepts mandated by federal law.

15. **Cancer Advisory Program.**

MAG supports continued funding of the Cancer Advisory Program, which also has to go through the Senate and House Appropriations Committees.

16. **Right-to-Die Legislation.** MAG supports.

Introduced last year by MAG member and member of the Georgia General Assembly, J. Roy Rowland, M.D., it passed the House of Representatives and failed in the Senate Human Resources Committee. This bill will be reintroduced in 1979, and MAG endorses and supports this legislation.

The following is a list of bills that we anticipate to be introduced in some form. MAG will specify its position when it reviews each bill.

1. **Physicians' Assistants, Nurse Practitioners, Physician Extenders.**

We anticipate legislation by one, if not all, of the above groups expanding the definition of their respective licensure and certification acts.

2. **Podiatric Hospital Privileges.**
3. **Podiatric Insurance Privileges.**
4. **Mental Illness Commitment Laws.**

5. **Mental Illness/Mental Retardation.** Change in current laws.
6. **Clinical Laboratory Law Changes.**
7. **Alcoholic Legislation.**
8. **Child Abuse Legislation.**
9. **Radiology Legislation.** Change of supervisory structure as to what governmental agency oversees radioactive waste, etc.

As stated earlier, there is specific legislation of concern to radiologists, pediatricians, ophthalmologists, orthopedists, psychiatrists, and other specialties. *All of these legislative items pertain to the practice of medicine and concern all medical doctors for the betterment of their patients and their practice.*

Help us! We need your help to attain the legislative goals we have set for 1979-80. Beginning January 15, you will receive the LEGISLATIVE BULLETIN dealing with issues of concern each week during the session. Help your colleagues, and your colleagues will help you. (This is, quite simply, the law of compensation so eloquently and accurately discussed by R. W. Emerson. Or, in the words of another famous Man, "Give, and it shall be given unto you.")

If you have any questions regarding any of this legislation or if you would like to become more active in the legislative process and visit the State Capitol for a day during the Legislature, please contact Mr. Rusty Kidd at the MAG Headquarters office.

Knowledge is a sacred cow, and my problem will be how we can milk her while keeping clear of her horns.
Albert Szent-Györgyi [1893-]: Science 146:1278, 1964.

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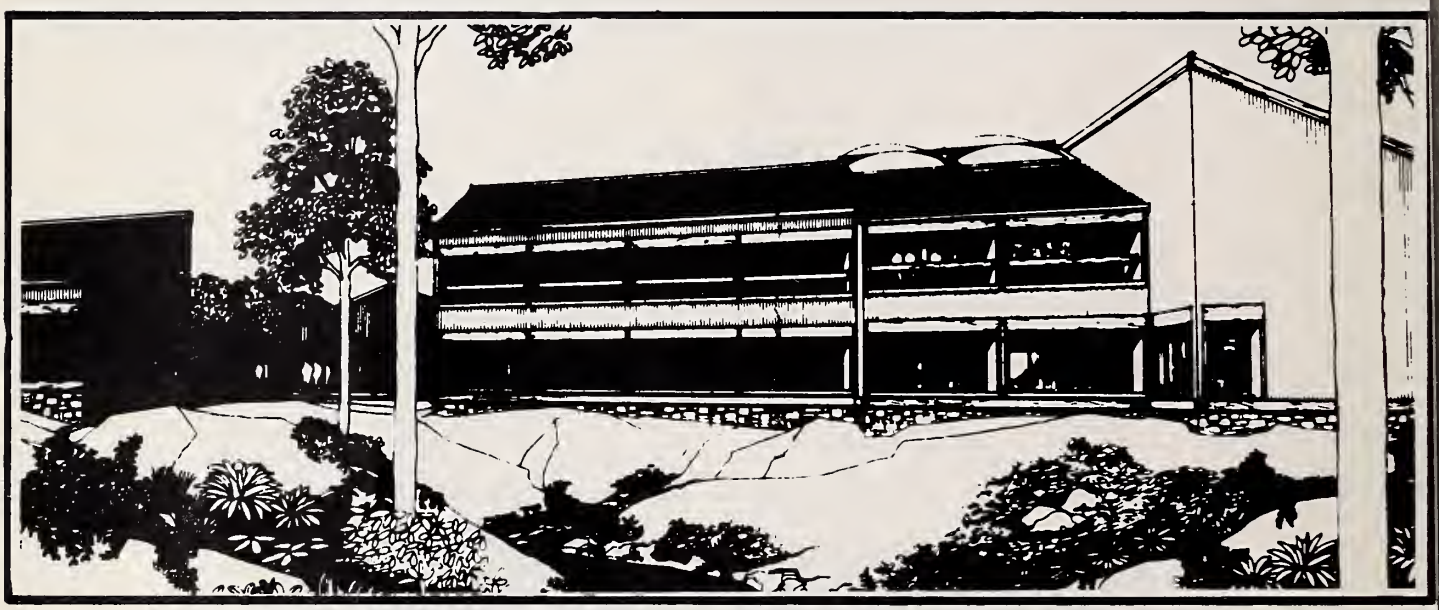


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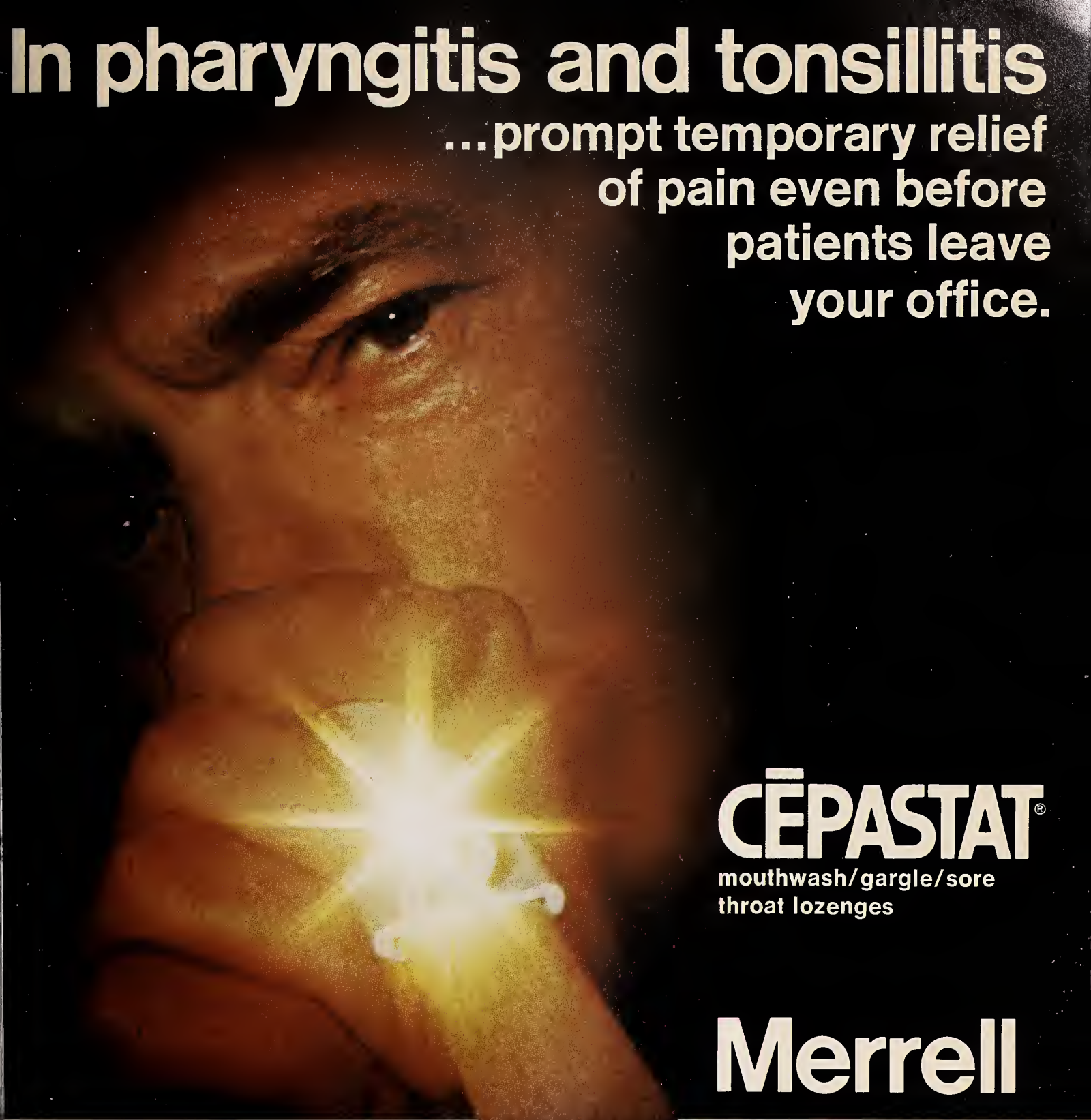
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...ying the throat with CĒPASTAT ...gs soothing relief within minutes. ...patients will appreciate this relief ...e waiting for therapeutic measures ...ke hold. The well-established ...thetic effects of CĒPASTAT pro- ...soothing temporary anesthesia to ...rritated or inflamed oropharyngeal ...osa.

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...l as a spray, CĒPASTAT is more ... to deliver the most relief to the ...ful area of the throat.

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The liquid is best for use at home as a spray or gargle. Lozenges are ideal for patients on the go.

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relief of minor sore throat when patients want it . . .

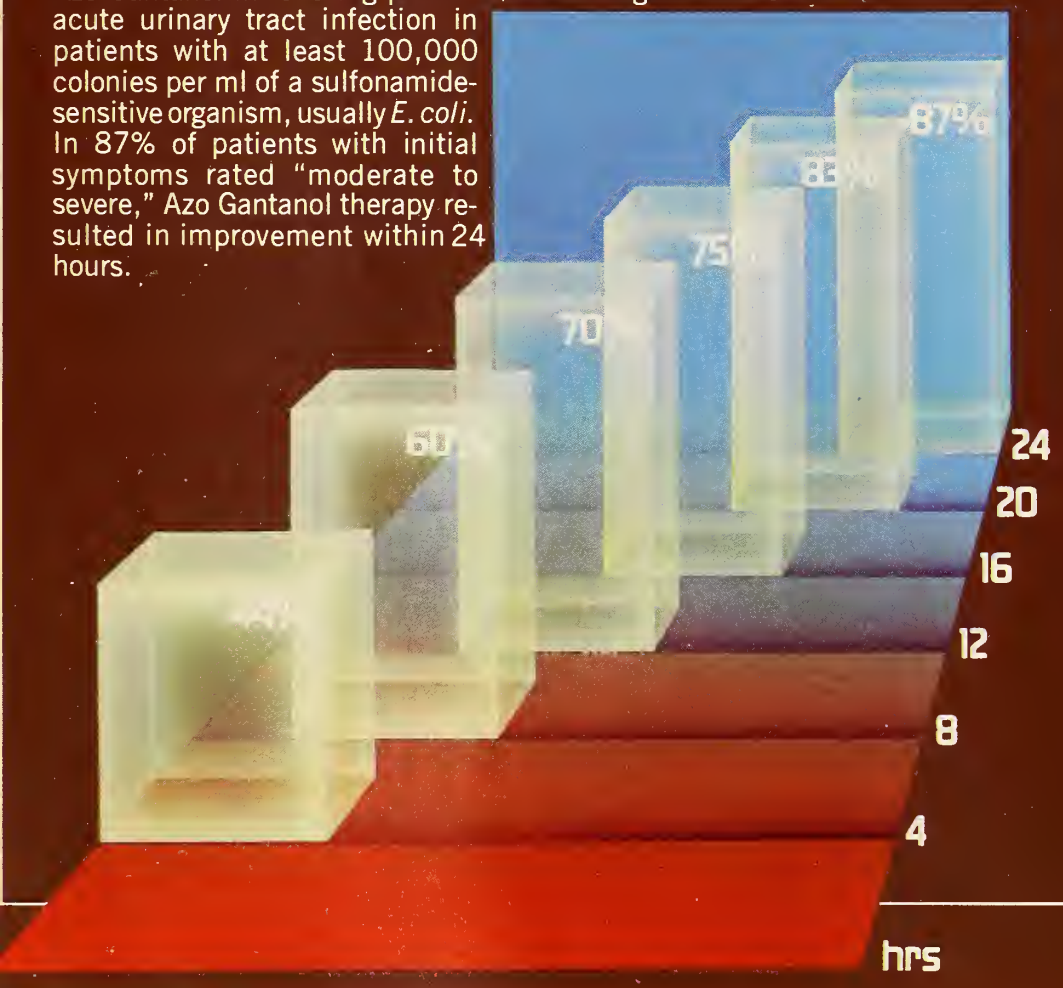
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(Y572A)

Important data on the pain of acute cystitis:

In 87% of patients studied [303 of 349], Azo Gantanol® reduced pain and/or burning within 24 hours*

A controlled, multicenter study assessed the efficacy of Azo Gantanol in relieving pain and/or burning associated with acute urinary tract infection in patients with at least 100,000 colonies per ml of a sulfonamide-sensitive organism, usually *E. coli*. In 87% of patients with initial symptoms rated "moderate to severe," Azo Gantanol therapy resulted in improvement within 24 hours.



Before prescribing, please consult complete p uct information, a summary of which follows:

Indications: In adults, urinary tract infections complicated by pain (primarily pyelonephritis pyelitis and cystitis) due to susceptible organ (usually *E. coli, Klebsiella-Aerobacter, Staph coccus aureus, Proteus mirabilis,* and, less fr quently, *Proteus vulgaris*) in the absence of obstructive uropathy or foreign bodies. **Note: fully coordinate *in vitro* sulfonamide sensitivi tests with bacteriologic and clinical response; aminobenzoic acid to follow-up culture media increasing frequency of resistant organisms li the usefulness of antibacterials including sul fonamides.** Measure sulfonamide blood level variations may occur; 20 mg/100 ml should b maximum total level.

Contraindications: Children below age 12; su fonamide hypersensitivity; pregnancy at term during nursing period; because Azo Gantanol tains phenazopyridine hydrochloride it is con dicated in glomerulonephritis, severe hepatiti uremia, and pyelonephritis of pregnancy with disturbances.

Warnings: Safety during pregnancy not establ Deaths from hypersensitivity reactions, agran tosis, aplastic anemia and other blood dyscra have been reported and early clinical signs (s throat, fever, pallor, purpura or jaundice) may dicate serious blood disorders. Frequent CBC urinalysis with microscopic examination are r ommended during sulfonamide therapy.

Precautions: Use cautiously in patients with i paired renal or hepatic function, severe allerg bronchial asthma; in glucose-6-phosphate dehydrogenase-deficient individuals in whom dose-related hemolysis may occur. Maintain adequate fluid intake to prevent crystalluria a stone formation.

Adverse Reactions: *Blood dyscrasias* (agran ulocytosis, aplastic anemia, thrombocytopeni leukopenia, hemolytic anemia, purpura, hypo thrombinemia and methemoglobinemia); *alle reactions* (erythema multiforme, skin eruptio Stevens-Johnson syndrome, epidermal necrol urticaria, serum sickness, pruritus, exfoliativ dermatitis, anaphylactoid reactions, periorbit edema, conjunctival and scleral injection, ph sensitization, arthralgia and allergic myocardi *G.I. reactions* (nausea, emesis, abdominal pa hepatitis, diarrhea, anorexia, pancreatitis and stomatitis); *CNS reactions* (headache, periph neuritis, mental depression, convulsions, ata hallucinations, tinnitus, vertigo and insomnia *miscellaneous reactions* (drug fever, chills, to nephrosis with oliguria and anuria, periarteriti nodosa and L. E. phenomenon). Due to certa chemical similarities with some goitrogens, d uretics (acetazolamide, thiazides) and oral hy glycemic agents, sulfonamides have caused r instances of goiter production, diuresis and h glycemia. Cross-sensitivity with these agents exist.

Dosage: Azo Gantanol is intended for the acu painful phase of urinary tract infections. *Usua adult dosage:* 2 Gm (4 tabs) initially, then 1 G (2 tabs) B.I.D. for up to 3 days. If pain persis causes other than infection should be sought. After relief of pain has been obtained, contin treatment with Gantanol (sulfamethoxazole) n be considered.

NOTE: Patients should be told that the orang dye (phenazopyridine HCl) will color the urine.

Supplied: Tablets, red, film-coated, each con ing 0.5 Gm sulfamethoxazole and 100 mg phenazopyridine HCl—bottles of 100 and 500

ROCHE

Roche Laboratories
Division of Hoffmann-La Roche
Nutley, New Jersey 07110

Fast pain relief plus effective antibacterial action

Azo Gantanol®

Each tablet contains 0.5 Gm sulfamethoxazole and 100 mg phenazopyridine HCl.

for the pain **for the pathogens**

*Data on file, Hoffmann-La Roche Inc., Nutley, New Jersey 07110.

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10 YEARS FINANCING

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A Report on MAG-SMA Scientific Assembly

Over 2,500 physicians attended the Scientific Assembly sponsored by the Medical Association of Georgia (MAG) and the Southern Medical Association (SMA) on November 11-14, 1978, at the World Congress Center in Atlanta. Including students, nurses, exhibitors, and guests over 4,200 persons attended this Assembly. This was the largest general medical meeting of its kind in the country, with scientific sessions in all 23 of the major specialties. The specialty societies in Georgia played an integral part in the successful planning of what turned out to be a valuable educational experience for the attendees.

E. Napier Burson, Jr., M.D., of Atlanta, general chairman of the 1978 Assembly, presided at the annual MAG Luncheon and Abner W. Calhoun Lecture on the opening day. Delivering the lecture was C. H. William Ruhe, M.D. (top right photo), Senior Vice President of the AMA, whose talk "1984: Nightmare or Utopia for Medical Education?" is printed in this issue of the *Journal*. Pictured on this and the next page are some of those who attended the luncheon and lecture.

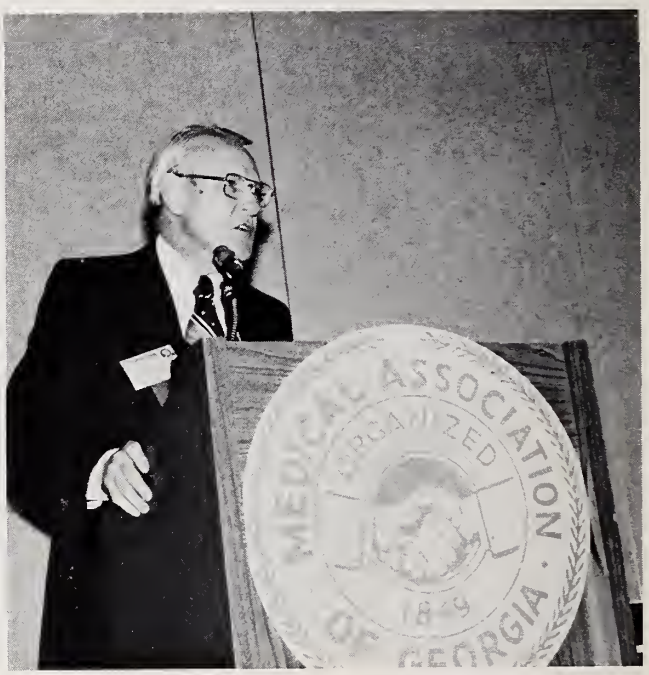
C. Rex Teeslink, M.D., of Augusta, was the MAG-SMA Program Coordinator, and Edwin C. Evans, M.D., of Atlanta, who originally thought of the combined meeting 4 years ago, served as Vice-Chairman of the SMA Council. Dr. Evans is a member of MAG's Committee on Education.

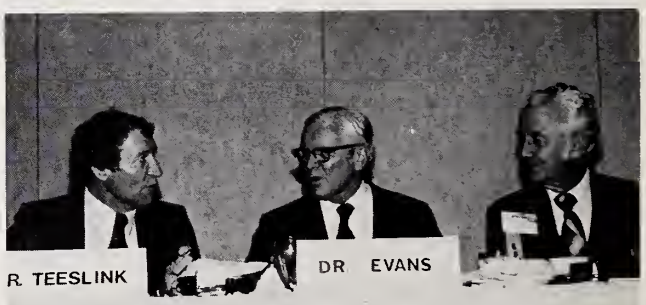
Complementing the full schedule of scientific sessions were 17 well-attended postgraduate courses on such topics as gynecologic oncology and care of the multiple injured patient. The spouses' program included 11 informative sessions on subjects ranging from body language to finances.

The SMA President's Night Dinner Dance, featuring a show by duo pianists Ferrante and Teicher, highlighted a full round of social events. Art Buchwald entertained the SMA President's Luncheon with his wit and story-telling ability, and a number of medical schools held alumni reunions.

Because of the resounding success of this Assembly, MAG and SMA officials hope to have another combined assembly when SMA returns to Atlanta in the fall of 1982.

MAG's own 1979 Scientific Assembly will be held November 15-18 at the Omni International Hotel in Atlanta. The 1979 Chairman is Dr. Mark M. Lindsey of Atlanta.











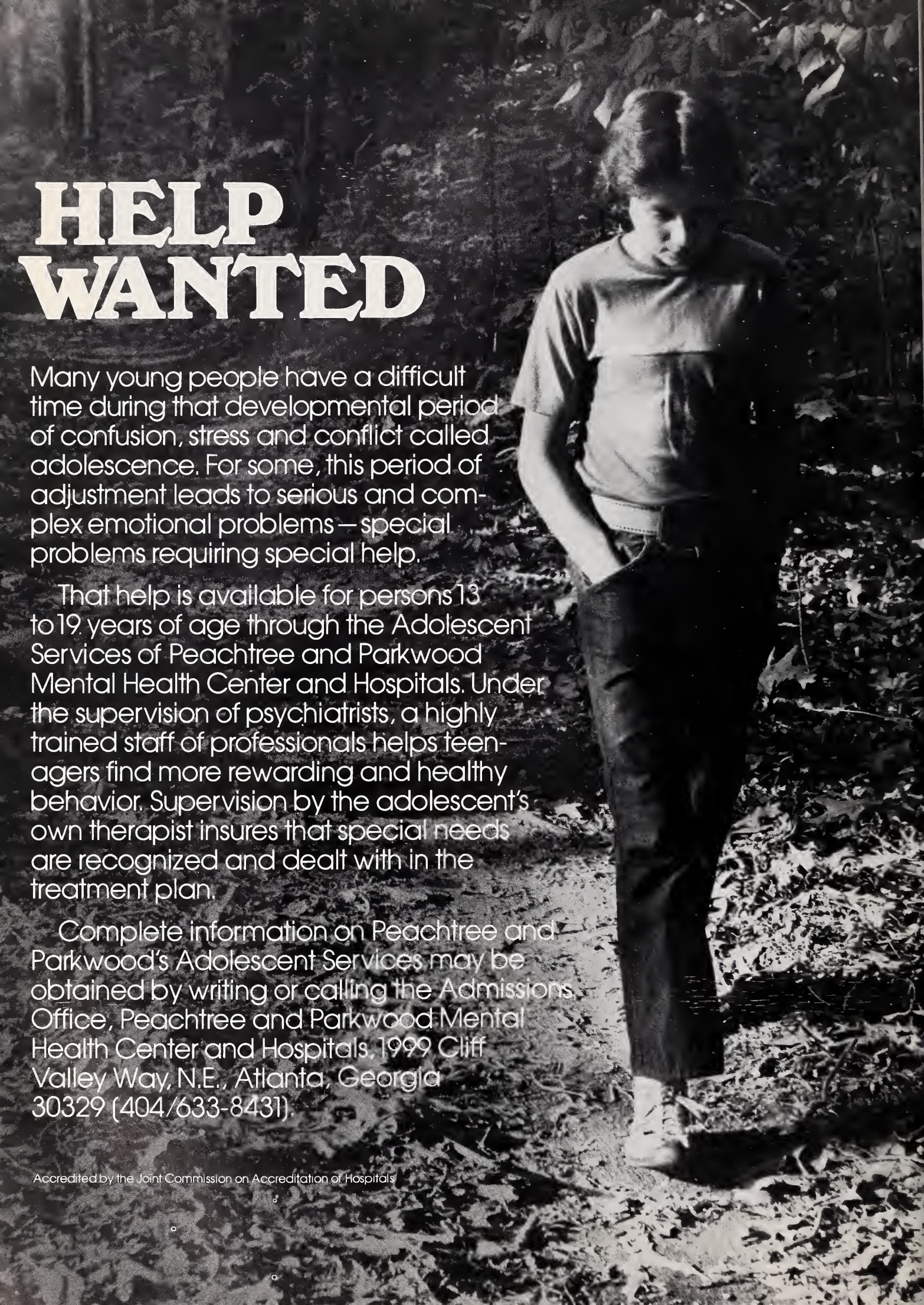












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Many young people have a difficult time during that developmental period of confusion, stress and conflict called adolescence. For some, this period of adjustment leads to serious and complex emotional problems—special problems requiring special help.

That help is available for persons 13 to 19 years of age through the Adolescent Services of Peachtree and Parkwood Mental Health Center and Hospitals. Under the supervision of psychiatrists, a highly trained staff of professionals helps teenagers find more rewarding and healthy behavior. Supervision by the adolescent's own therapist insures that special needs are recognized and dealt with in the treatment plan.

Complete information on Peachtree and Parkwood's Adolescent Services may be obtained by writing or calling the Admissions Office, Peachtree and Parkwood Mental Health Center and Hospitals, 1999 Cliff Valley Way, N.E., Atlanta, Georgia 30329 (404/633-8431).

Accredited by the Joint Commission on Accreditation of Hospitals

The 1978 Abner W. Calhoun Lecture:

"1984: Nightmare or Utopia for Medical Education?"

Delivered by C. H. WILLIAM RUHE, M.D.*

IT IS A GREAT PLEASURE and personal privilege to meet with you today to honor the memory of Dr. Abner Wellborn Calhoun, a medical educator and former President of the Medical Association of Georgia who figured prominently in the development of medicine in Georgia and in the South, and to participate in the joint Scientific Assembly of the Medical Association of Georgia and the Southern Medical Association.

The Orwellian title of my address today is deliberately symbolic. Only 6 years away, 1984 is a convenient target date for predictions; indeed, the way things are going these days, it is just around the corner. But the connection to Orwell's fantasy is much closer than a mere 5 or 6 years. For there has never been a time in *my* life when it has seemed so clear that Big Brother is watching.

Big Brother, in the form of Big Government, is truly watching medicine. If the watch were simply the normal, responsible monitoring of the expenditure of public monies for the delivery of health care, we could all feel comfortable about it. Unfortunately, there are times when it appears malevolent, rather than benign. It is difficult not to be paranoid about the activities of the various Congressional committees and governmental agencies, which seem to be aimed at harassment rather than support.

"The adequacy of the supply of manpower, or the public's perception of that adequacy, will determine the level of support and the nature of support which will be provided for medical education."

Certainly life and the practice of medicine were simpler in the old days. Can you remember when there were no Health Systems Agencies? No Professional Standards Review Organizations (PSRO)? No investigations of medicine by the Federal Trade Commission (FTC)? When we had never heard of "Medicaid Mills"? When Professional Liability was rarely a cause for worry, and it was easy to get insurance at low cost? When we didn't have Utilization Review? And MAC Regulations? When nobody was trying to put controls on the numbers, types, and location of residency programs?

* Dr. Ruhe is a Senior Vice President of the American Medical Association. His address is 535 N. Dearborn St., Chicago, IL 60610.

These things are so much a part of our lives today — like pestilence and the plague in the Middle Ages — that it almost seems like they have always been with us. But when I joined the American Medical Association (AMA) staff in 1960, not a single one of them was a major problem. Most of them had never been heard of, or even dreamed of, by an unsuspecting profession!

"Eventually, the M.D. degree may be granted only at the successful completion of residency training and, like the Ph.D., may be granted in a specific discipline."

I mention these things only to point out two facts of a general nature which will influence the direction of medical education in the future: 1) events are moving very rapidly, and there may be new developments by 1984 of which we have no present knowledge; and 2) there is likely to be increasing involvement of Big Brother in future years.

Recognizing these facts, let me go at once to a series of predictions. In some instances, I will be indicating the direction events appear to be taking, as I look at them, and in others I will indicate things which are likely to happen if we do not take protective action to prevent them from happening. Some are almost certain to happen. Others are much less likely, or may be much farther in the future than 1984. The predictions are:

1. The public perception of the need for more physicians will be satisfied in the early 1980's.
2. Federal capitation support for medical schools will be discontinued about the same time or even sooner.
3. Although more new medical schools will continue to be established in the next few years, some existing medical schools will be forced to close.
4. Many, if not most, medical schools will reduce the size of their classes.
5. There will be increased pressure for regulation of the numbers, types, and location of residency programs.
6. Jurisdictional disputes among various medical specialties, and between medicine and various allied health professions (particularly nursing and pharmacy), will become one of the major problems of the medical profession.

7. Jurisdictional disputes will lead to pressures within the profession for regulation and restriction of educational programs.

8. There will be pressures from within and from outside the profession for limited licensure of physicians, i.e., limited both in time and in specialty.

9. Completion of residency training will become a requirement for licensure.

". . . we now have a ratio of one physician to every 505 people in the United States."

10. Regular participation in continuing medical education will become a *de facto* requirement for all physicians to continue to practice medicine.

11. Universities will exercise greater control over residency training within their jurisdiction, and there will be increasing pressure to bring all graduate medical education under university surveillance.

12. With residency training compulsory, or nearly so, the significance of the M.D. degree will increasingly be called in question. Eventually, the M.D. degree may be granted only at the successful completion of residency training and, like the Ph.D. today, may be granted in a specific discipline, e.g., M.D. in Surgery, M.D. in Family Practice, M.D. in Radiology.

13. Specialty board certification will change in nature and may even be supplanted by specialized M.D. degrees. Specialty boards will come under increasing pressure from the FTC and others as alleged elitist groups in restraint of competition. Board certification may become a prerequisite for licensure limited to a specialty field.

14. Increasing legislation and regulation of the practice of medicine, and increasing demand for public accountability in health care, will lead to a kind of cookbook medicine, where almost all procedures and therapy are prescribed by federal agencies or review bodies such as the Food and Drug Administration (FDA) and PSRO's. This will have profound implications for medical education, since it will promote standardized learning rather than independent thinking.

"Since it was first proclaimed by Lyndon Johnson in 1968 that there was a shortage of 50,000 physicians, we have had a net increase of over 100,000 physicians."

15. The processes of accreditation and certification increasingly will be subject to public scrutiny.

Now that we have entered a few of these for the record, so to speak, let us go back and re-examine some of them and try to understand them a little better. I began with some predictions about physician manpower because it seems obvious to me that the manpower supply, which is the product of the educational system or industry, is a very important determinant of the nature of medical education. The adequacy of the supply of manpower, or the public's perception of that adequacy, will determine the level of support and the nature of support which will be provided for medical education.

The supply of physicians has grown substantially over the last 15 years. During most of that period the annual net rate of growth of the physician population has averaged better than 3% per year and has been increasing, while the annual net growth rate for the general population has been less than 1% per year and has been decreasing. At the end of 1977, we had 437,000 M.D. and D.O. physicians. The gross physician-to-population ratio has grown from 149 physicians per 100,000 population in 1963 to 198 per 100,000 at the end of 1977. To put it another way, we now have a ratio of one physician to every 505 people in the United States. Since it was first proclaimed by Lyndon Johnson in 1968 that there was a shortage of 50,000 physicians, we have had a net increase of over 100,000 physicians.

In spite of this substantial growth in supply of physicians, there is still a shortage of physician services. Most of these relate to a perceived lack of primary care services, but it is also true that there are

"It is the Congressional view that the demand [for physicians] has been satisfied, or nearly satisfied, and that capitation support [of medical schools] is therefore no longer needed."

certain types of highly specialized services which are not in full or adequate supply. Furthermore, there are pressures in existence and in development which seem likely to cause a greater demand for services in the future, and new regulations governing admission of foreign medical graduates to this country are likely to slow the rate of growth of the physician population. Consequently, it is still too early to say that we have too many doctors or that we will soon have too many doctors. The AMA Council on Medical Education, in considering this subject recently, adopted the following statement:

> "The present trend to provide facilities for educating an increasing number of physicians should be supported and not curtailed. The public can best be served under an educational system which maximizes the freedom of individuals to choose and develop their career interests and opportunities under normal competitive conditions. This applies to both the selec-

tion of medicine as a career and the choice of a specialty.''

The Council goes on in its two-page statement to point out that new technologic developments and highly specialized procedures require the services of increasing numbers of physicians and that there are many variables in the future, such as national health insurance, which may alter substantially the perception of numbers of physicians needed. Consequently, although the United States Congress has formally stated that there is no longer a shortage of physicians (in the last Health Manpower Act) and HEW Secretary Califano has spoken publicly of an excess of physicians, the AMA is not willing to make such a statement at this time.

". . . I predict that federal capitation support for medical schools will be discontinued by the early 1980's."

It is interesting that, a few months ago, the Department of Health, Education, and Welfare (DHEW) announced new criteria for the designation of areas in which there is a shortage of physicians. By a stroke of the pen, this immediately raised from 16 million to 25 million the number of people living in areas of physician shortage. More recently (October 26, 1978), DHEW Secretary Califano, speaking before the Institute of Medicine, stated that 51 million Americans live in medically underserved areas. Admittedly, this is more political than substantive, but it does show how tenuous the definitions of physician shortage are.

But let us examine for a moment the status of American medical schools. For the past 2 decades, there has been a very strong pressure on medical schools to expand the size of their classes and to produce more physicians, and there has been very strong pressure for the production of new medical schools in many parts of the country. In 1963, at the time the first Health Professions Educational Assistance Act was passed, we had 87 accredited medical schools. As of the end of 1977, there were 122 medical schools fully accredited, with provisional accreditation or with letters of reasonable assurance of accreditation. In addition, there were about a dozen others in various stages of planning or contemplation. The 35 new schools constitute a 40% increase in the total numbers of medical schools. During the same period, the enrollment in all medical schools increased from 31,491 in 1963 to 58,266 in 1977, an 85% increase. There has been a 50% increase in enrollment since 1970 and a 100% increase in enrollment since 1960.

You will recall that I predicted that federal capitation support for medical schools would be discontinued by the early 1980's. It does not take any great wisdom or vision to foretell this development, since it has been considered openly in House and Senate committees, in DHEW, and in the Office of Management and Budget. It seems clear that the Congressional intent in providing capitation support was not, as the medical schools had hoped, to provide an undergirding financial base for medical education, but rather was to increase the supply of physicians because of the public demand. It is the Congressional view that that demand has been satisfied, or nearly satisfied, and that capitation support is therefore no longer needed.

In Secretary Califano's address before the Association of American Medical Colleges (AAMC) in New Orleans last month, he did not state flatly that capitation support would be discontinued, but he certainly implied it. As they were saying in the halls at the AAMC meeting, DHEW is moving from capitation to decapitation of the medical schools.

Medical schools are, in fact, entering a new era of financial hardship. In a period when costs have been rising steadily because of inflation and the increase in the size of enrollments, the federal contribution has been leveling off and even declining. The result has been a marked change in the nature of medical school support. As noted in last year's Education Number, ''the federal dollar accounted for more than half of medical school operating revenue ten years ago; now the Federal Government provides less than 40%.''

In view of these fiscal facts, and with strong governmental pressures for cost containment, it is easy to understand the prediction that some existing medical schools will be forced to close in the coming years, primarily because of fiscal problems. Already there are at least two medical schools in serious financial condition, and several others are not far behind.

"The AMA has been resisting very strongly any efforts to prescribe by legislation or regulation the specific numbers or proportions of residency positions in the various specialties and their location."

Reduction in class size is likely to follow or accompany the reduced capitation allowances. At the AAMC meeting, Mr. Califano stated that, ''It is our hope — indeed our objective — that over the next few years the medical schools will gradually decrease the size of their classes.'' In state-owned universities, however, increased enrollments are likely to be sustained so long as there is perception of the need for more physicians within those states and so long as there are strong pressures from large numbers of disappointed, well-qualified medical

school applicants and their families. The applicant pressure is likely to ease somewhat in the immediate years ahead, since the total number of applicants to medical school has declined slightly in each of the past 2 years and will very likely decline still more in the next 2 years, while the size of the first-year classes will continue to grow. The applicant-to-acceptance ratio is therefore declining and will continue to decline modestly in the immediate years ahead. The decline in number of applicants is due to the declining number of students who will reach age 22 during the next few years, since the number of applicants to medical school has been shown over many years to parallel almost exactly the number of students reaching age 22.

The need for numbers of additional physicians appears to have been met or nearly met by the medical education system, but public and governmental interest continues to grow in the determination of the *types* of physicians and their location in practice. The attention of Congressional committees has been focused upon regulation of the number, type, and location of residency programs in an effort to increase the proportion of physicians going into primary-care specialties. While the situation has become somewhat obfuscated by debate over the relative merits of family physicians, general internists, general pediatricians, and general obstetricians-gynecologists in

". . . the profession will come out at a higher mean level of performance through establishing standards of excellence and encouraging and exhorting the profession to achieve them rather than through setting a legal requirement at the minimum level of competence."

providing primary care services to the public, the Congressional intent seems clear. Furthermore, there has been supporting testimony by such bodies as the Institute of Medicine, the General Accounting Office, the Josiah Macy Foundation and other groups (including some within the profession).

The AMA has been resisting very strongly any efforts to prescribe by legislation or regulation the specific numbers or proportions of residency positions in the various specialties and their location. It is our belief that any such prescription would inevitably prove to be restrictive and would impede the efforts of the profession to adapt to changing conditions and societal needs. Few people in Congress, and unfortunately relatively few people within the profession, seem to understand that tampering with the educational system through legislation and regulation would very likely have seriously adverse effects in the long run.

With the growth in numbers of physicians, inevitably the number of jurisdictional disputes will increase. These disputes will occur among different specialties in medicine over who has the right to do what, under what circumstances, and in what setting. In addition, there will be increasing friction between physicians and allied health professionals, particularly those in nursing and pharmacy, where self-determination and independent practice are growing aspirations.

". . . Eli Ginsberg [has] pointed out that one of the problems with the financing of graduate medical education is that the public did not really understand that it takes 8 years to make a physician and had never really contracted to support medical education for 8 years instead of 4."

At the educational level, the jurisdictional pressures are likely to lead to a desire for greater regulation and restriction of educational programs in order that these might be tailored to direct the activities of future graduates into more narrowly confined practice activities. These tendencies will be aided and abetted by a growing public concern about permanent, unrestricted licensure of all health professionals, including physicians.

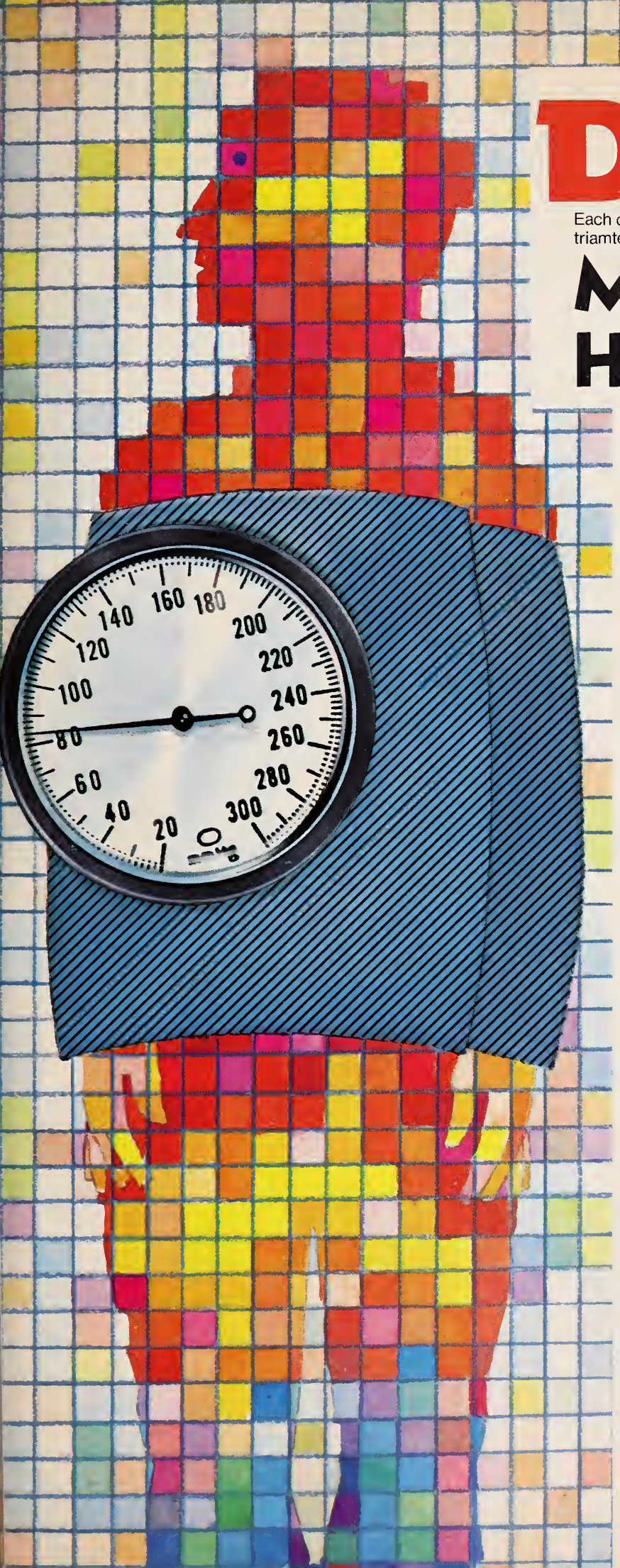
It is easy to predict that completion of residency training will become a requirement for licensure in most states in the years ahead. It is indeed surprising that this has not already occurred, since virtually all medical graduates today take full residency training before entering practice. Law usually follows custom, rather than the reverse, and legislation to require formally what has already transpired as a professional practice seems very likely to occur in the future.

Participation in continuing medical education (CME) at some level has already become a requirement by law in 23 states as of the date of this address, although some of them have not yet implemented the requirement. When one adds the states in which there is a continuing education requirement for maintenance of membership in the state medical association and those where there are requirements for malpractice self-insurance plans, the total number of states reaches 37. In my opinion, this

"Medical schools are . . . entering a new era of financial hardship."

means that we have already passed the point where participation in continuing medical education has become, *de facto,* a requirement for virtually all

(Continued on page 27)



Dyazide®

Each capsule contains 50 mg. of Dyrenium® (brand of triamterene) and 25 mg. of hydrochlorothiazide.

Makes Sense in Hypertension*

Before prescribing, see complete prescribing information in SK&F Co. literature or *PDR*. A brief summary follows:

* **Warning**
This drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual. If this combination represents the dosage so determined, its use may be more convenient in patient management. Treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

Contraindications: Further use in anuria, progressive renal or hepatic dysfunction, hyperkalemia. Pre-existing elevated serum potassium. Hypersensitivity to either component or other sulfonamide-derived drugs.

Warnings: Do not use potassium supplements, dietary or otherwise, unless hypokalemia develops or dietary intake of potassium is markedly impaired. If supplementary potassium is needed, potassium tablets should not be used. Hyperkalemia can occur, and has been associated with cardiac irregularities. It is more likely in the severely ill, with urine volume less than one liter/day, the elderly and diabetics with suspected or confirmed renal insufficiency. Periodically, serum K+ levels should be determined. If hyperkalemia develops, substitute a thiazide alone, restrict K+ intake. **Associated widened QRS complex or arrhythmia requires prompt additional therapy.** Thiazides cross the placental barrier and appear in cord blood. Use in pregnancy requires weighing anticipated benefits against possible hazards, including fetal or neonatal jaundice, thrombocytopenia, other adverse reactions seen in adults. Thiazides appear and triamterene may appear in breast milk. If their use is essential, the patient should stop nursing. Adequate information on use in children is not available.

Precautions: Do periodic serum electrolyte determinations (particularly important in patients vomiting excessively or receiving parenteral fluids). Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics or those with suspected or confirmed renal insufficiency. Watch for signs of impending coma in severe liver disease. If spironolactone is used concomitantly, determine serum K+ frequently; both can cause K+ retention and elevated serum K+. Two deaths have been reported with such concomitant therapy (in one, recommended dosage was exceeded, in the other serum electrolytes were not properly monitored). Observe regularly for possible blood dyscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving triamterene, and leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with thiazides. Triamterene is a weak folic acid antagonist. Do periodic blood studies in cirrhotics with splenomegaly. Antihypertensive effect may be enhanced in post-sympathectomy patients. Use cautiously in surgical patients. The following may occur: transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), hyperuricemia and gout, digitalis intoxication (in hypokalemia), decreasing alkali reserve with possible metabolic acidosis. 'Dyazide' interferes with fluorescent measurement of quinidine.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis, rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting, diarrhea, constipation, other gastrointestinal disturbances. Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and, rarely, allergic pneumonitis have occurred with thiazides alone.

Supplied: Bottles of 100 and 1000 capsules; Single Unit Packages of 100 (intended for institutional use only).

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10 mg. capsules, 20 mg. tablets,
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helps control abnormal motor activity with minimal anticholinergic side effects†

Demonstrated smooth muscle relaxant activity.

In this double-blind study, twenty patients having G.I. series and exhibiting spasm were randomly selected to receive either 2 cc. of Bentyl or sodium chloride intramuscularly. Ten minutes after the injection another radiograph was taken . . .

. . . Bentyl produced definite relaxation in 8 of 10 patients. The sodium chloride produced relaxation in only 3 of 10. No side effects occurred in either group of patients.



Pylorospasm has almost totally blocked passage of barium meal.



Barium meal beginning to pass 10 minutes after intramuscular injection of 20 mg. Bentyl.

"The correlation of spasm relief and drug given was excellent."

*This drug has been classified "probably" effective in treating certain functional G.I. disorders.

†See Warnings, Precautions and Adverse Reactions.

See following page for prescribing information.

Reference:
King, J.C. and Starkman, N.M.: Evaluation of an antispasmodic. Double-blind evaluation to control gastrointestinal spasms occurring during radiographic examination. A preliminary report. Western Med. 5:356-358, 1964.

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8-3497 (Y515A)

Bentyl®

(dicyclomine hydrochloride USP)

Capsules, Tablets, Syrup, Injection
AVAILABLE ONLY ON PRESCRIPTION.

Brief Summary
INDICATIONS
For use as adjunctive therapy in the treatment of peptic ulcer.
IT SHOULD BE NOTED AT THIS POINT IN TIME THAT THERE IS A LACK OF CONCURRENCE AS TO THE VALUE OF ANTICHOLINERGICS/ANTISPASMODICS IN THE TREATMENT OF GASTRIC ULCER. IT HAS NOT BEEN SHOWN CONCLUSIVELY WHETHER ANTICHOLINERGIC/ANTISPASMODIC DRUGS AID IN THE HEALING OF A PEPTIC ULCER, DECREASE THE RATE OF RECURRENCES, OR PREVENT COMPLICATION.

Based on a review of this drug by the National Academy of Sciences–National Research Council and/or other information, FDA has classified the following indications as "probably" effective:

May also be useful in the irritable bowel syndrome (irritable colon, spastic colon, mucous colitis, acute enterocolitis, and functional gastrointestinal disorders); and in neurogenic bowel disturbances (including the splenic flexure syndrome and neurogenic colon).

THESE FUNCTIONAL DISORDERS ARE OFTEN RELIEVED BY VARYING COMBINATIONS OF SEDATIVE, REASSURANCE, PHYSICIAN INTEREST, AMELIORATION OF ENVIRONMENTAL FACTORS.

For use in the treatment of infant colic (syrup).

Final classification of the less-than-effective indications requires further investigation.

CONTRAINDICATIONS: Obstructive uropathy (for example, bladder neck obstruction due to prostatic hypertrophy); obstructive disease of the gastrointestinal tract (as in achalasia, pyloroduodenal stenosis); paralytic ileus, intestinal atony of the elderly or debilitated patient; unstable cardiovascular status in acute hemorrhage; severe ulcerative colitis; toxic megacolon complicating ulcerative colitis; myasthenia gravis. WARNINGS: In the presence of a high environmental temperature, heat prostration can occur with drug use (fever and heat stroke due to decreased sweating). Diarrhea may be an early symptom of incomplete intestinal obstruction, especially in patients with ileostomy or colostomy. In this instance treatment with this drug would be inappropriate and possibly harmful. Bentyl may produce drowsiness or blurred vision. In this event, the patient should be warned not to engage in activities requiring mental alertness such as operating a motor vehicle or other machinery or perform hazardous work while taking this drug. PRECAUTIONS: Although studies have failed to demonstrate adverse effects of dicyclomine hydrochloride in glaucoma or in patients with prostatic hypertrophy, it should be prescribed with caution in patients known to have or suspected of having glaucoma or prostatic hypertrophy. Use with caution in patients with: autonomic neuropathy; hepatic or renal disease; ulcerative colitis–Large doses may suppress intestinal motility to the point of producing a paralytic ileus and the use of this drug may precipitate or aggravate the serious complication of toxic megacolon; hyperthyroidism, coronary heart disease, congestive heart failure, cardiac arrhythmias, and hypertension; hiatal hernia associated with reflux esophagitis since anticholinergic drugs may aggravate this condition.
It should be noted that the use of anticholinergic/antispasmodic drugs in the treatment of gastric ulcer may produce a delay in gastric emptying time and may complicate such therapy (antral stasis). Do not rely on the use of the drug in the presence of complication of biliary tract disease. Investigate any tachycardia before giving anticholinergic (atropine-like) drugs since they may increase the heart rate. With overdosage, a curare-like action may occur. ADVERSE REACTIONS: Anticholinergics/antispasmodics produce certain effects which may be physiologic or toxic depending upon the individual patient's response. The physician must delineate these. Adverse reactions may include xerostomia; urinary hesitancy and retention; blurred vision and tachycardia; palpitations; mydriasis; cycloplegia; increased ocular tension; loss of taste; headache; nervousness; drowsiness; weakness; dizziness; insomnia; nausea; vomiting; impotence; suppression of lactation; constipation; bloated feeling; severe allergic reaction or drug idiosyncrasies including anaphylaxis; urticaria and other dermal manifestations; some degree of mental confusion and/or excitement, especially in elderly persons; and decreased sweating. With the injectable form there may be a temporary sensation of lightheadedness and occasionally local irritation. DOSAGE AND ADMINISTRATION: Dosage must be adjusted to individual patient's needs.
Usual Dosage: Bentyl 10 mg. capsule and syrup: *Adults*: 1 or 2 capsules or teaspoonfuls syrup three or four times daily. *Children*: 1 capsule or teaspoonful syrup three or four times daily. *Infants*: ½ teaspoonful syrup three or four times daily. (May be diluted with equal volume of water.) Bentyl 20 mg.: *Adults*: 1 tablet three or four times daily. Bentyl Injection: *Adults*: 2 ml. (20 mg.) every four to six hours intramuscularly only. NOT FOR INTRAVENOUS USE. MANAGEMENT OF OVERDOSE: The signs and symptoms of overdose are headache, nausea, vomiting, blurred vision, dilated pupils, hot, dry skin, dizziness, dryness of the mouth, difficulty in swallowing, CNS stimulation. Treatment should consist of gastric lavage, emetics, and activated charcoal. Barbiturates may be used either orally or intramuscularly for sedation but they should not be used if Bentyl with Phenobarbital has been ingested. If indicated, parenteral cholinergic agents such as Urecholine® (bethanecol chloride USP) should be used.
Product Information as of October, 1976

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physicians to practice medicine. We may, therefore, quit arguing over whether continuing medical education should be compulsory or voluntary. The argument never did make any sense, because it had long since been decided by the profession that it was every physician's professional responsibility to keep up-to-date through regular renewal of medical knowledge and skills.

". . . there is a strong feeling among university people that all residency training should be under the control of the university."

Professional determination of what is necessary to remain up-to-date and in good standing in the profession is a far more potent force than legislation. Consider the following facts: 1) in 1910, 70% of American medical graduates voluntarily took a year of internship before entering practice, although the first state licensure law requiring a year of internship was passed in Pennsylvania in 1914; 2) completion of full residency training is overwhelmingly the rule for medical graduates today even though there is no law which requires it. The profession has long since agreed, implicitly if not explicitly, that modern graduates in medicine do not enter practice without first completing residency training.

Does it then make any difference whether we have the laws or not? I am aware that you are wrestling with this problem at the present time, in attempting to determine whether CME should be made compulsory, either for re-registration of the license to practice or for membership in the medical society. I think that it does make a difference, and in general, I would oppose having such requirements written into law, because some of the laws are likely to become too detailed and too specific and, almost inevitably, too rigid and restrictive. Furthermore, the imposition of onerous and time-consuming documentation requirements does not really improve the standards of either medical education or medical practice. The main impact is only to impose more paper work and

"If the movement toward regulation and restriction of specialized medical education continues, it will be only natural at that point to award the M.D. degree in an individual specialty."

take up everybody's time. Perhaps the laws are necessary to deal with the small percentage of laggards in the profession, but I suspect that better ways could be found to deal with such problems.

In addition, there is the real danger that the laws may have a depressing effect upon aspirations toward excellence. Obviously, the legal requirements must be set at a level which can be achieved by the vast majority of the profession without unreasonable effort; otherwise, a large proportion of the profession would be disenfranchised by the law, and there would be a great public outcry. Most physicians can, therefore, easily meet the legal requirements and, having done so, may be inclined to be content with that and not be concerned with the real questions of whether they are indeed maintaining their competence and practicing good scientific medicine.

It has always been my contention that the profession will come out at a higher mean level of performance through establishing standards of excellence and encouraging and exhorting the profession to achieve them rather than through setting a legal requirement at the minimum level of competence.

I have the same quarrel with those who would make specialty board certification a requirement for licensure. To do so would, in my opinion, destroy specialty board certification as a stimulus to excellence in performance. Standards for certification

"If residency training becomes a prerequisite for licensure, is it therefore not logical to expect that licensing bodies will demand that those completing the residency training also become certified by the specialty board in that field?"

would have to be set low enough to enable the vast majority of physicians to achieve them. There would then be no higher target of excellence for physicians to shoot at, and there would be a strong soporific effect upon the profession to be content with achieving the minimum legal requirements.

There is another problem with attempting to legislate and regulate levels of medical education which is somewhat more subtle but in the long run is a much more serious danger. Consider for a moment the requirement in the existing Health Manpower law that certain percentages of the graduates of all of the medical schools collectively enter the first year of residency training in primary care specialties. We have long since arrived at the requirement for 1978 — we had even before the law was written — and in 1977 the legal requirement set for 1980 had already been achieved. Well, then, what is the harm in it, you might ask? The harm is that, even though the letter of the law has been satisfied, the perceptions of those responsible for writing the law have not been satisfied.

This is always one of the dilemmas with legislation. Different legislators and different segments of the public have different perceptions of what impact the law will have and what results it will bring. Frequently, the satisfaction of the letter of the law

does not relieve their underlying feelings which led to the passage of the law in the first place. We now have what, to many, is a surprising turn of events in which the legislators appear to be angry with the medical schools for having met their goals too soon. The fact is that the legislation did not actually express the feelings of insecurity and the perceived needs of society. The law was passed because many people thought that, through it, they would be able to have an ideal distribution of physicians, with a family physician for every family regardless of geographic area or economic status. Many others thought that the production of more family physicians would decrease the cost of health care. Until these rather ethereal goals have been satisfied, most legislators will not be happy with the fact that educational institutions have met the specific legal requirements. Inevitably, the result is that there will be further legislation and further regulation until the public perception of need has been assuaged.

"The growing interest of the public and legislative bodies in the quality of medical care may very well lead to a restriction in the latitude of an individual physician's judgment in carrying out both diagnostic and therapeutic procedures."

I have tried to point this out to some of our professional colleagues but have had great difficulty in getting them to look beyond the levels of the immediate requirements. They do not seem to understand that satisfying the legislators concerning the composition of residency programs is only an intermediate step. If, in fact, their underlying needs are not met by such legislation they will inevitably attempt to dictate not only the location but also the specific terms of practice of the products of these residency programs in years to come. This will lead to prescription of the limits of practice for each individual physician and very likely to the limitation of licensure through legislation or regulation.

The prospect of limited licensure to practice inevitably raises questions about the significance of the M.D. degree. It is clear that the M.D. degree no longer means what it once did and that it probably means different things to the public and to the profession. We have already pointed out that virtually no modern graduate enters practice until the completion of full residency training, 3 to 5 years after receipt of the M.D. degree. Yet to the public, the M.D. degree means that the holder is prepared to take care of sick people as an independent practitioner. At a recent meeting, Eli Ginsberg pointed out that one of the problems with the financing of graduate medical education is that the public did not really understand that it takes 8 years to make a physician and had never really contracted to support medical education for 8 years instead of 4.

There are many people in university circles who are very concerned about the fact that this second half of medical education is frequently beyond the control of the medical school which granted the M.D. degree. This is one of the reasons why there is a strong feeling among university people that all residency training should be under control of the university. The AAMC has already adopted a policy statement to this effect, but it has not been supported by the Coordinating Council on Medical Education or the Liaison Committee on Graduate Medical Education.

Undoubtedly, pressures will increase in future years to bring all residency training under university control. Whether this occurs or not, it is likely that there will be increasing experimentation with the design and implementation of integrated undergraduate-graduate educational experiences. Some of these already exist but they are not very numerous today. If such programs grow in number, it seems likely that serious consideration will be given to withholding the M.D. degree until the completion of the total program. If the movement toward regulation and restriction of specialized medical education continues, it will be only natural at that point to award the M.D. degree in an individual specialty. Just as a Ph.D. is awarded today in biochemistry or physiology, it might then become the practice to award the M.D. degree in pathology, family medicine, or dermatology. Such categorical degrees would strongly increase the impetus toward limited licensure. We have already observed manifestation of this trend in one or two states where it has been proposed that licensure be withheld from residents who are in training in the so-called nonbedded specialties, and where there has not been a general year of clinical medicine at the graduate level.

"The movement to me appears to be toward a kind of cookbook medicine where everything which can and should be done is prescribed by some type of national standard-setting body."

Residency training leads naturally to eligibility for specialty board certification. The two, while not identical, are certainly associated strongly in the minds of both those providing the certification and those seeking it. If residency training becomes a prerequisite for licensure, is it therefore not logical to expect that licensing bodies will demand that those completing the residency training also become cer-

tified by the specialty board in that field? Such questions have already been raised by at least one licensing body and are likely to be the subject of serious consideration by others. If this happens, it will certainly make a difference in the nature of specialty board certification as we have known it. The specialty boards and the American Board of Medical Specialties are very seriously examining this entire subject.

"Only strong, conscious, and continuing efforts will suffice to maintain the freedom of the educational process and of the clinical practice of physicians."

The educational movement toward greater restriction and regulation is paralleled by what is taking place at the practice level. The growing interest of the public and legislative bodies in the quality of medical care may very well lead to a restriction in the latitude of an individual physician's judgment in carrying out both diagnostic and therapeutic procedures. In his address to the AMA's Leadership Conference last winter, Senator Kennedy proposed that there be a national commission to study practice habits, with one of its charges to determine what is appropriate practice for the delivery of quality medical care. At the same time, proposed new drug legislation would greatly increase the authority of the FDA to spell out the conditions under which drugs might be used and to identify for patients the indications, contraindications, side effects, and anticipated results from the use of various drugs.

In a recent article in the *Washington Post* entitled, "HEW's Prescription for Doctors," Daniel Greenberg wrote, ". . . HEW's newly-created National Center for Health Care Technology will accelerate a little-noted process that is already exerting considerable influence on medical practice: the systematic evaluation of both new and traditional forms of diagnosis and treatment. In tandem with a unique exercise recently initiated by the National Institutes of Health, in which assemblages of medical specialists devise guidelines for the uses of specific medical technologies, this new federally conducted evaluation role is shaping up as one of the most powerful forces in contemporary medicine. Though the conclusions are not binding on the profession, a physician employing practices in conflict with the guidelines could easily be risking malpractice suicide."

"The times cry out for unity within the profession — for a strong and unified AMA."

The movement to me appears to be toward a kind of cookbook medicine, where everything which can and should be done is prescribed by some type of national standard-setting body. The physician who then departs from these prescribed practices may be in serious danger of litigation for malpractice if things do not turn out well or, more simply, he may not be paid by third party payers for carrying out procedures and practices which have not been identified by the national bodies.

I have no doubt that some of this will come to pass. Perhaps some of it would be desirable. The trick will be to keep it within reasonable limits where the individual physician-patient encounter remains something more than a matching of a list of symptoms against a list of procedures.

One of the strengths of the American medical education system has been its diversity and its emphasis on the use of sound judgment in the management of patient problems. Perhaps I am wrong, but it appears to me that it will be increasingly difficult to preserve these values in the years ahead. Only strong, conscious, and continuing efforts will suffice to maintain the freedom of the educational process and of the clinical practice of physicians.

"At times we are inclined to forget that medicine is a profession of service and that our only reason for having a system of medical education is to provide people who will serve the public."

These matters are very much the concern of the AMA. Indeed, it is only the AMA which has the breadth of interest and function to permit a full understanding of their implications for both education and practice. The times cry out for unity within the profession — for a strong and unified AMA. Under the circumstances, it is a tragic development that four major specialty societies are suing the AMA over a dispute about chiropractic legislation. The enemies of medicine must be sitting back, chuckling to themselves, waiting to pick off the divided elements of the profession.

Where does all this leave us in 1984? Will it be utopia or nightmare for medical education? The answer, of course, is neither. We will obviously be between those extremes. My predictions may have depressed you, and, indeed, I have emphasized problems in my presentation, but I want to make it clear that I am essentially optimistic about the future of medical education and medical practice in this country. Obviously, there are places where it will be necessary that we be both wise and vigilant, but it appears to me that we have in place most of the mechanisms and structures necessary to exercise the

proper surveillance and leadership.

We will inevitably be working more in the public arena, in the spotlight of public interest, and we must be sure that we have our house in order and that we carry out our functions in the best interest of the public. At times we are inclined to forget that medicine is a profession of service and that our only reason for having a system of medical education is to provide people who will serve the public. At times our technical procedures and our organizational prerogatives rise up to block our view of the larger goal. We sometimes become so busy with the *process* of education and accreditation that we overlook its *purpose*.

There are many challenges ahead for medical education and the profession of medicine. We must deal with the agonizing subjects of the cost of education and the cost of medical care. We must find ways to finance medical education effectively and efficiently, while preserving the freedom and independence of the system. To do so, we must be responsive to public needs and interests. We must identify future problems and initiate solutions to them before legislative pressure develops.

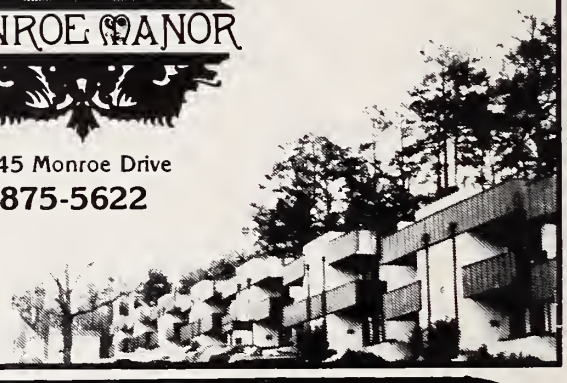
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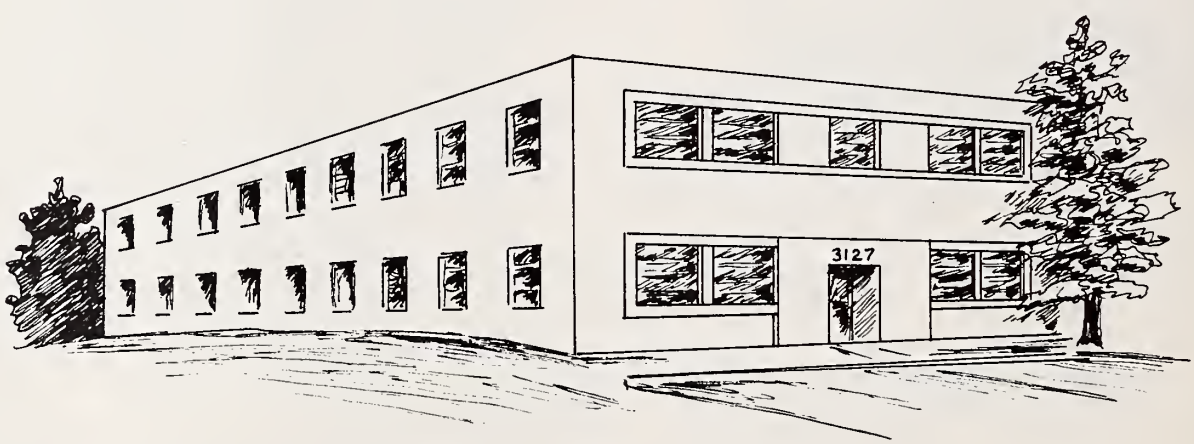
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". . . somehow, as a result of jogging, the quality of our lives really does improve."

Marathon Man, or Jogging Can Be Fun!

WILLIAM J. MORTON, M.D., *Chamblee**

On April 17, 1978, I won the 82nd annual Boston Marathon. Bill Rogers thought he won it in 2 hours and 10 minutes, but my 4 hours and 45 minutes was by far the sweeter victory. You see, Rogers was in a different race. Oh, yes, we were both in the same crowd of 5,000 runners, but Rogers was running against the jocks, the Olympic-hopefuls, and the record. I was running against a far more significant opponent — me! What makes a recently-turned 40-year-old man, with a history of being an average athlete, decide to train and run in what has to be one of the most grueling and exhausting examples of self discipline in all American sports? Why does one impose on one's self the rigid discipline and denial of other more pleasurable pursuits that training for the marathon requires? The answer is simple: I don't know!

The image recorded on my cerebral cortex coincident with my crossing the finish line in Boston is etched there permanently. It is right next to watching my first-born arrive, graduating from medical school, and taking my first solo flight as a student pilot! There are a few brief moments in all our lives that will always stand out and be available for recall, and so it is with the Boston Marathon. Even the sights and smells can be recalled years from now.

The Boston Marathon is the prototype of the only purely athletic event left in the United States. Not counting television coverage, it draws more people than the Kentucky Derby or the Super Bowl. Yet is is absolutely devoid of commercialism. Nobody gets paid, nobody negotiates contracts, nobody works out television packages. Almost anyone can enter. The official entrants have to qualify from a previous marathon, but the unofficial entrants number in the thousands. I ran next to a 73-year-old man from Copenhagen for a while (he finished 15 minutes *ahead* of me) and got very chummy with a nurse from the Massachusetts General Intensive Care Unit. (He dropped out on Heartbreak Hill.) The wheelchair entrants started 15 minutes ahead of us (and I never saw one of them for the entire 26.2 miles).

What made the race were the spectators. Lining the course every foot of the way, from Hopkinton to Boston, over 250,000 people watched me! They were eager to hand out water, gatorade, beer, ice cubes, and orange slices. I felt guilty when I refused some of their handouts. The girls at Wellesley were the most fantastic of all. Wellesley is the half-way mark, and at this point the very slight hint of fatigue starts to appear. It was also at Wellesley that I heard that Bill Rogers had won the marathon. (Incredulously, *I* was at the half-way point starting to ache, and *he* was getting screamed at by 35,000 people at the finish line!) But back to Wellesley. The girls lined up so close that we had to run through single file. What a thrill! The cheering was thunderous, and with their shouting encouragement and offering refreshments, it was impossible not to sprint through their mile corridor at top speed. The adrenaline poured out and kept me going for another few miles until the hills.

Heartbreak Hill! There it was, finally, what I had heard about, read about, and even driven over (backwards and forwards) the day before the race. Starting from about the 16.5 mile mark to the 21 mile mark, this series of hills will do it to you. The pain intensifies, and now you start trying to convince yourself that the whole idea of pursuing this madness is silly, masochistic, and done only to impress your friends. The psychologic barrier has to be crossed. Knowing this will happen to you, you try to keep those thoughts from entering your head. ("Hi, Miss, where you from? California? Ever done this before? Hurts, doesn't it? Want the rest of this ice cube? You're looking pretty good. See you in Boston!") Soon (150 light years later) the hills are behind you, and there are only 5 miles left to go. It's not all down hill from here, though, and when the slightest little incline comes you almost get angry at anyone who is yelling at you, telling you it's all down hill!

But the best is now coming up! You come to the

* Dr. Morton is a urologist. His address is 3646-F Chamblee-Tucker Rd., Chamblee, GA 30341.

last three tenths of a mile, and the crowd in the Prudential Square is hysterical. You turn the corner, run about a block, and up a ramp into a screaming mass of humanity. The pain is pretty bad, your legs feel like stumps, but with strength from somewhere, the last burst of speed emerges, and you cross the finish. Now comes the outpouring of emotions — pain, fatigue, relief, exhilaration, and a feeling of accomplishment. They are all jumbled together, and, not strangely at all, you begin to cry. Everybody goes through it, a few don't admit it, but cry I did, and I will never forget it. Even now I can feel it all over again.

What is it about jogging anyway? What is happening to us? Everywhere you look, there is a jogger loping along. Sweating, grimacing, and obviously in pain, but still plugging ahead. Is it good for us? Does it really offer immortality? Does it give us more svelte, trim bodies, better sex lives, greater cardiac reserve, etc.? Maybe. Possibly. The final answers are not in, but it does indeed appear to make us healthier, more aware of our natural selves, and somehow, the quality of our life really does improve.

I am not going to discuss training for the marathon because being an over achiever, impatient, and curious, I latch onto one idea and then explode with enthusiasm, but jogging can be maintained and achieved by even the most amateur of us.

Let's start at the beginning — the way to get into it and the what to do and not to do about jogging. First of all, remember that everybody starts out the same way: short of breath, pain in the legs, stitch in the side, and disbelief that "I am actually doing this to myself?" Be patient, this first early stage will soon pass and something extraordinary happens: one can actually jog from more than one telephone pole to another.

Soon the distance increases and within a week or 2, jogging a mile is an attainable goal. I remember the first time I finished a mile. Incredulous? Happy? Runners high? You bet! All of the above, and from then on it was a challenge. There are many facets of jogging. When one becomes transformed from a jogger into a runner is difficult to ascertain. In a non-running crowd, it is less presumptuous to call yourself a jogger, but actually, as strength, endurance, and attitude improve, one really is a runner, which can be described as the graduate school of jogging.

As you do for any other adventure, prepare yourself for this one. If you are over 40 years of age, see your cardiologist for a stress test. If you are under 40, see your cardiologist for a stress test. No, I am not a cardiologist, but unless you are in that 1% segment of the population that is in superb physican condition, cardiac evaluation is of prime importance before you get started. Get the proper footwear. Of all the sports and hobbies one can become involved in, running is probably one of the least expensive. The biggest expense of all should be your shoes. Indulge yourself a little and splurge! Spend about $30 for a good pair of shoes; it definitely makes running more comfortable. Good shoes do not give you the wings of Mercury nor the floating euphoria of a psychologic high, but it will stop your toes from bleeding and your heels from cracking. Read all you can about jogging. Go to your favorite book store and buy a book about running. Go to the local sporting goods store, and find out about all the newsletters available and about what's going on in the racing world. Join the American Medical Joggers Association (AMJA). This excellent organization publishes a monthly newsletter, with excerpts about all aspects of running from all over the world. The Atlanta Marathon held every January is preceded by a day's worth of meetings sponsored by the AMJA. Attend some of the free clinics in town sponsored by the Atlanta Track Club in the sporting goods stores. Learn more about nutrition. (Remember what the Kreb Cycle is? How about anaerobic metabolism? What's good, or bad, about lactic acid?) By all means stop (or at least curtail) smoking. (One outstanding feature I noted in Boston was at the very crowded meeting rooms at the Copley Plaza Hotel on the few days prior to the race, where 300 to 400 people were gathered: not one wisp of smoke was evident. What a delight!) Besides, if the aesthetic idea of not smoking doesn't appeal to you, the blow torch in your lungs will do much to convince you that cigarettes and running are incompatible.

Learn the rules of the road. For example, run facing traffic, and be very wary of all automobiles. It is amazing how many folks will actually aim for you. If you run at night, wear light or reflective clothing. Treat dogs with proper respect. First of all, remember that they can out run you no matter how fast you think you are. They are also very territorial, and after they bark and scare you to death as you go by their front lawn, they will usually retreat if you keep on going. (If they don't, ask the Lord for *help*!) I have had a few scares from big dogs, but mainly, as some great philosopher said (or was it my grandmother?), their bark is worse than their bite!

The "what-not-to-do's" are simple. Just re-read the past few paragraphs from the negative side. For example, don't over do it, don't start out unprepared, don't skimp on shoes, don't — well, you get the message.

O.K. folks, that's the message for today. Now go do it! Hopefully, you will get the fever, too. The impressive shifting of body fat will encourage you. The general feeling of well being is delightful and will prompt you to continue. These results are within your reach. Make a run for them!

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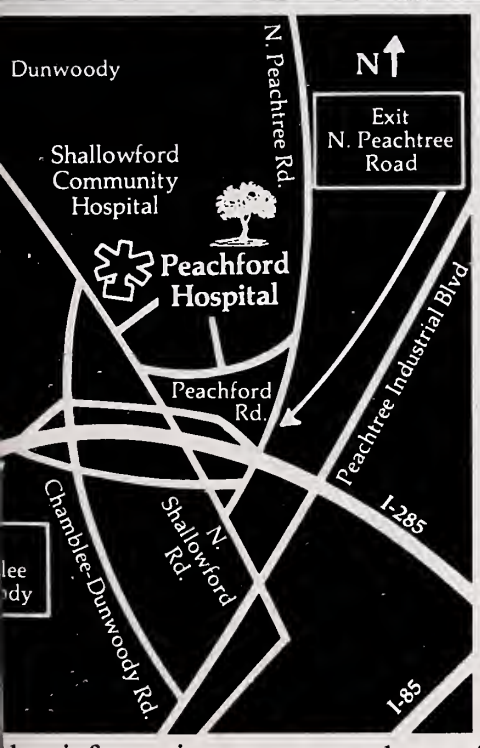
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Paraneoplastic syndromes may well precede overt evidence of malignancy.

Idiopathic Schwartz-Bartter Syndrome: An Indication for Screening Fiberoptic Bronchoscopy

A. S. ELGUINDI, M.D., B. A. CHAUDHARY, M.D., G. N. HARRISON, M.D., *and* WILLIAM A. SPEIR, JR., M.D., *Augusta**

THE SYNDROME of inappropriate antidiuretic hormone secretion (Schwartz-Bartter) occurs most often in patients with malignancies, but may occur in association with a variety of diseases and drugs. It is the most common paraneoplastic syndrome associated with oat-cell carcinoma.[1-3] We report a patient with idiopathic Schwartz-Bartter Syndrome whose chest radiographs, including tomography, were repeatedly interpreted as normal. The diagnosis of oat-cell carcinoma was established by screening fiberoptic bronchoscopy.

A 54-year-old man was admitted to his local hospital with a 6-month history of anorexia and a 20-pound weight loss. He reported having had a mild morning cough for many years, but denied expectoration, hemoptysis, or fever. He had smoked two to three packages of cigarettes daily for over 30 years, and denied alcohol intake. He was taking no medications and had no history of prior surgery. Intermediate strength (5 TU) PPD skin test had been positive for many years. The serum sodium was 120 mEq/L. No abnormal findings were reported on physical examination, and chest radiographs, liver-spleen scan, and computerized axial tomography of the brain were reported as normal. The patient was discharged. Two weeks later, he was admitted to the Augusta Veterans Administration Hospital.

Physical examination, including complete neurological evaluation, was within normal limits. Skin turgor was good, and there was no evidence of edema. Chest radiograph was interpreted as normal (Figure 1), and comparison with previous films revealed no changes. Pertinent laboratory findings were as follows: serum sodium 121 mEq/L, potassium 3.7 mEq/L, chlorides 85 mEq/L, carbon dioxide content 27 mEq/L; serum alkaline phosphatase 208 IU; serum osmolality 253 m Osm/kg; urine sodium 92 mEq/L, and urine osmolality 606 m Osm/kg. Repeat chest radiographs, including oblique views and tomography, were interpreted as normal. Multiple sputum examinations for acid-fast bacilli and subsequent cultures were negative. Sputum cytology was negative. Serum T_3, T_4, and fasting cortisol levels were within normal limits. Febrile agglutinin titers were non-reactive. Upper gastrointestinal series, barium enema, bone and brain scans were interpreted as normal. Lumbar



Figure 1. Posteroanterior radiograph of the chest taken upon the patient's admission to the hospital.

* Drs. Elguindi, Chaudhary, Harrison, and Speir are associated with the Section of Pulmonary Diseases, Department of Medicine, Medical College of Georgia and the Veterans Administration Hospital in Augusta. Direct reprint requests to Dr. Elguindi, Section of Pulmonary Diseases, Department of Medicine, Medical College of Georgia, Augusta, GA 30902.

puncture and bone marrow aspiration were normal. Percutaneous biopsy of the liver revealed a few scattered epithelioid granulomas. With fluid restriction, the serum sodium rose to 136 mEq/L. The patient was discharged from the hospital at his request.

One week later, he was readmitted. Serum sodium was 122 mEq/L. Screening fiberoptic bronchoscopy was performed, and a friable mass was seen partially occluding the orifices to the left upper lobe and lingular bronchi. Forceps and brush biopsies, as well as post-bronchoscopy sputum, showed oat-cell carcinoma. The patient was referred for radiotherapy (to be followed by chemotherapy). Following the first course of radiotherapy, the serum sodium was 138 mEq/L.

Comment

Hyponatremia is a common clinical problem. After more common causes such as dilutional hyponatremia, pseudo-hyponatremia, and salt-wasting due to renal or adrenal diseases are excluded, the syndrome of inappropriate antidiuretic hormone secretion is considered. The usual criteria for diagnosis of the Schwartz-Bartter Syndrome include low serum sodium and serum osmolality with increased urine sodium and urine osmolality, in the absence of clinical evidence of fluid depletion or edema. The Schwartz-Bartter Syndrome may be associated with a number of drugs, and with endocrine, central nervous system, and pulmonary diseases.[1, 2]

This patient met the diagnostic criteria for the syndrome of inappropriate antidiuretic hormone secretion. Extensive diagnostic studies, including serial chest radiographs and tomography, failed to reveal an underlying cause. Thus, the apparent final diagnosis could well have been idiopathic Schwartz-Bartter Syndrome had screening bronchoscopy not been performed. However, malignancy, particularly of the lung, should always be suspected in a patient with inappropriate antidiuretic hormone secretion. We conclude that any patient in whom the diagnosis of idiopathic Schwartz-Bartter Syndrome is being considered should undergo screening fiberoptic bronchoscopy.

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2. DeTroyer A, Demanet JC: Clinical, biological, and pathogenic features of the syndrome of inappropriate secretion of antidiuretic hormone. Quart J Med 45:521, 1976.
3. Moss AM, Miller M, Streeten DHP: Pathophysiologic and pharmacologic alterations in the release and action of ADH. Metabolism 25:697, 1976.

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Indications. For the treatment of ascariasis (roundworm infection) and enterobiasis (pinworm infection).

Warnings. *Usage in Pregnancy:* Reproduction studies have been performed in animals and there was no evidence of propensity for harm to the fetus. The relevance to the human is not known.

There is no experience in pregnant women who have received this drug.

The drug has not been extensively studied in children under two years; therefore, in the treatment of children under the age of two years, the relative benefit/risk should be considered.

Precautions: Minor transient elevations of SGOT have occurred in a small percentage of patients. Therefore, this drug should be used with caution in patients with preexisting liver dysfunction.

Adverse Reactions. The most frequently encountered adverse reactions are related to the gastrointestinal system.

Gastrointestinal and hepatic reactions: anorexia, nausea, vomiting, gastralgia, abdominal cramps, diarrhea and tenesmus, transient elevation of SGOT.

CNS reactions: headache, dizziness, drowsiness, and insomnia. Skin reactions: rashes.

Dosage and Administration. *Children and Adults:* Antiminth Oral Suspension (50 mg of pyrantel base/ml) should be administered in a single dose of 11 mg of pyrantel base per kg of body weight (or 5 mg/lb.); maximum total dose 1 gram. This corresponds to a simplified dosage regimen of 1 ml of Antiminth per 10 lb. of body weight. (One teaspoonful=5 ml.)

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So it is not surprising that in this short period Motrin has become the most frequently prescribed alternative to aspirin. Motrin relieves joint pain and inflammation as effectively as indomethacin or aspirin, but causes significantly fewer CNS and milder GI reactions. However, gastrointestinal bleeding, sometimes severe, has been associated with Motrin, aspirin, indomethacin, and other nonsteroidal antiarthritic agents.

*The safety and effectiveness of Motrin have not been established in patients with Functional Class IV rheumatoid arthritis (incapacitated, largely or wholly bedridden, or confined to wheelchair; little or no self-care).

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Motrin 400 mg TABLETS
ibuprofen, Upjohn

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Indications and Usage: Treatment of signs and symptoms of rheumatoid arthritis and osteoarthritis during acute flares and in long-term management. Safety and efficacy have not been established in Functional Class IV rheumatoid arthritis.

Contraindications: Individuals hypersensitive to it, or with the syndrome of nasal polyps, angioedema and bronchospastic reactivity to aspirin or other nonsteroidal anti-inflammatory agents (see WARNINGS).

Warnings: Anaphylactoid reactions have occurred in patients with aspirin hypersensitivity (see CONTRAINDICATIONS).

Peptic ulceration and gastrointestinal bleeding, sometimes severe, have been reported. Ulceration, perforation, and bleeding may end fatally. An association has not been established. Motrin should be given under close supervision to patients with a history of upper gastrointestinal tract disease, only after consulting ADVERSE REACTIONS.

In patients with active peptic ulcer and active rheumatoid arthritis, nonulcerogenic drugs, such as gold, should be tried. If Motrin must be given, the patient should be under close supervision for signs of ulcer perforation or gastrointestinal bleeding.

Precautions: Blurred and/or diminished vision, scotomata, and/or changes in color vision have been reported. If these develop, discontinue Motrin and the patient should have an ophthalmologic examination, including central visual fields.

Fluid retention and edema have been associated with Motrin; use with caution in patients with a history of cardiac decompensation.

Motrin can inhibit platelet aggregation and prolong bleeding time. Use with caution in persons with intrinsic coagulation defects and those on anticoagulant therapy.

Patients should report signs or symptoms of gastrointestinal ulceration or bleeding, blurred vision or other eye symptoms, skin rash, weight gain, or edema.

To avoid exacerbation of disease or adrenal insufficiency, patients on prolonged corticosteroid therapy should have therapy tapered slowly when Motrin is added.

Drug interactions. *Aspirin* used concomitantly may decrease Motrin blood levels. *Coumarin:* Bleeding has been reported in patients taking Motrin and coumarin.

Pregnancy and nursing mothers: Motrin should not be taken during pregnancy or by nursing mothers.

Adverse Reactions

Incidence greater than 1%

Gastrointestinal: The most frequent type of adverse reaction occurring with Motrin (ibuprofen) is gastrointestinal (4% to 16%). This includes nausea*, epigastric pain*, heartburn*, diarrhea, abdominal distress, nausea and vomiting, indigestion, constipation, abdominal cramps or pain, fullness of the GI tract (bloating and flatulence). **Central Nervous System:** Dizziness*, headache, nervousness. **Dermatologic:** Rash* (including maculopapular type), pruritus. **Special Senses:** Tinnitus. **Metabolic:** Decreased appetite, edema, fluid retention. Fluid retention generally responds promptly to drug discontinuation (see PRECAUTIONS).

Incidence: Unmarked 1% to 3%; *3% to 9%.

Incidence less than 1 in 100

Gastrointestinal: Upper GI ulcer with bleeding and/or perforation, hemorrhage, melena. **Central Nervous System:** Depression, insomnia. **Dermatologic:** Vesiculobullous eruptions, urticaria, erythema multiforme. **Cardiovascular:** Congestive heart failure in patients with marginal cardiac function, elevated blood pressure. **Special Senses:** Amblyopia (see PRECAUTIONS). **Hematologic:** Leukopenia, decreased hemoglobin and hematocrit.

Causal relationship unknown

Gastrointestinal: Hepatitis, jaundice, abnormal liver function. **Central Nervous System:** Paresthesias, hallucinations, dream abnormalities. **Dermatologic:** Alopecia, Stevens-Johnson syndrome. **Special Senses:** Conjunctivitis, diplopia, optic neuritis. **Hematologic:** Hemolytic anemia, thrombocytopenia, granulocytopenia, bleeding episodes. **Allergic:** Fever, serum sickness, lupus erythematosus syndrome. **Endocrine:** Gynecomastia, hypoglycemia. **Cardiovascular:** Arrhythmias. **Renal:** Decreased creatinine clearance, polyuria, azotemia.

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An Introduction to Private Enterprise Perspectives on Medicine

STEPHEN C. MAY JR., M.D., *Kennesaw**

WHAT INSTITUTIONS determine the direction of our health and medical care delivery system? What is the derivation of the driving force of future medicine?

Reflect on the alternatives: The American Medical Association (AMA)? The public perceives the AMA as a giant labor union, and, indeed, many physicians feel they are not represented by the AMA. The federal government? Secretary Califano has been in a quandary trying to reduce medical care costs and, by striking out in all directions, has accomplished little. The insurance industry? Many present attitudes emanate from the policies of insurance companies in the past and all third party payers now. The medical schools? It has been said by medical educators "The way we teach in the medical schools today is the way medicine will be practiced 10 years from now."

In view of the fact that 60% of Americans, at this time, feel that there is a crisis in health and medical care, and in view of the fact that the federal government looks on it as a *nonsystem,* what are the implications as to past policy and directions for the future?

The obvious answer to the question posed above is that the *people* will determine the direction, particularly with abdication of responsibility by their institutions. The needs of the people, *as they perceive them,* will be met. The AMA and the medical schools of this country have not been as attentive as they could have been to the perceived needs of the American people. The federal government in its medical school funding (prior to 1970) and its payment policies, along with the insurance industry's payment policies, have combined to form an unholy, albeit unplanned, alliance to create the system we have now. The law of supply and demand has been circumvented by maldistribution and fragmentation. Maldistribution and fragmentation are present in our state and even in our hospital staffs and are continually encouraged by third-party policies.

Enthoven states about health insurance and government: ". . . the private market for health insurance, *as presently constituted and shaped by numerous government policies,* does a poor job of allocating resources, and fails to meet important social objectives."[1]

The fact is that there is an unlimited demand for medical services. If the third party is to limit the demand, it should be done on the front end. The problem is compounded further by a fourth party, the employer, being interposed in the matter. Consequently, the employer (fourth party) contracts with the insurance company (third party) guaranteeing that the doctors (second party) will give the patient (first party) what he *desires/needs,* at a cost acceptable to all. Interpose the federal government (fifth party) into this, and it becomes even more confused.

Whether government or private enterprise dominates, the system must be cost effective. Cost-effective care necessitates a physician who was taught cost consciousness in school, had this reinforced in a residency program, and practices as a physician who, in my estimation (admittedly biased), has an overview of the patient's total health and medical care needs, and will assume the responsibility for coordinating all of its myriad facets. In the absence of such a physician other alternatives must be accepted.

* Dr. May is a member of the MAG Committee on Education and Chairman of the planning committee for the Seminar on Private Enterprise Perspectives on Medical Practice. His address is South Main St., Kennesaw, GA 30144.

Reference

1. Enthoven A: Consumer-Choice Health Plan, Part 1. New Engl J Med 298(12):650-658, March 23, 1978.

It is probably true, as philosophers say, that life must be understood backwards. But they forget the other proposition, that it must be lived forwards.
Sören Kierkegaard [1813-1855]: Journal.

Seminar on Private Enterprise Perspectives on Medicine

(PEP Seminar)

CRAIG E. ARONOFF, Ph.D., *and* FRANCIS W. RUSHING, Ph.D., *Atlanta**

WITH HEALTH BILLS SOARING and the perpetual proposals from the banks of the Potomac about various forms of regulation being applied to America's system of health care, there is much confusion these days about the economics of medicine. Because of this, the Chair of Private Enterprise at Georgia State University and the Medical Association of Georgia will conduct a seminar on "Private Enterprise Perspectives on Medical Practice," (or PEP Seminar) slated for May 26 and 27, 1979, at the Colony Square Hotel in Atlanta.

Instructional sessions on the first day of the seminar will present "The Marketplace of Medicine," "Economic Pressures on the Medical Profession: Who's Raising the Fuss and Why," and "The Nature of Regulation."

"The Marketplace of Medicine" will apply economic concepts, including supply and demand, competition, pricing, values, choices, and trade offs, to the understanding of the structure of medical markets. Part of this discussion will deal with the characteristics of medical market structure and the level and nature of competition in medical services. How prices for medical services are determined and what influence market and nonmarket factors play in establishing these prices and the rate at which they change will also be examined.

"Pressures on the Medical Profession" will explore the responses of various societal institutions to the costs of medical care. Big business, big labor, and big government have all responded in various ways, depending on their particular needs and values. The insurance companies obviously have a stake in both the problems and solutions. Consumer groups, the poor, and other groups have also chimed in. This session will focus on what these groups are saying and why.

In "The Nature of Regulation," we will explore the meaning of regulation and show that the question is not "whether or not to regulate" but rather "who or what shall regulate and how." The implications of the various types of regulation, including market regulation, self regulation, third-party regulation, and governmental regulation, will be considered.

On the second day of the seminar, task forces of physicians will work with economists to develop feasible solutions to real problems confronting the medical profession. Using insights and tools gained on the first day of the seminar, the participants will deal with such problems as: the distribution of medical services, the medical arms race and the cost of medical technology, the economics of defensive medicine, national health insurance, and the right to health.

This seminar is intended to help physicians achieve a better understanding of the economic dimensions of health care delivery. With this understanding they will be better able to handle problems regarding medical costs and distribution. The suggested market solutions will address current problems with minimal government regulation, and additional alternatives will be introduced to what now seems to be only a choice between the status quo and nationalizing the health care system.

* Dr. Aronoff is Assistant Professor of Management and Communications and Associate to the Chair of Private Enterprise. Dr. Rushing is Associate Professor of Economics, Director of the Center for Business and Economic Education, and Director of the Georgia Council on Economic Education. They will be the principal instructors for this seminar. Their address is Department of Management, Georgia State University, Atlanta, GA 30303.

Learning without thinking is useless. Thinking without learning is dangerous.
Confucius [551-478 B.C.]: Analects, *Bk. II, Ch XV (tr. by William E. Soothill).*

History of a Chair

Georgia State University's Chair of Private Enterprise, the first educational effort of its kind in the nation, was established in 1963. From its inception, the Chair has been funded through relatively small donations from individuals, businesses, and foundations, now totaling about $60,000 per year.

The Chair has a number of programs designed for students, teachers, professionals, business people, and the general public to promote understanding of the American private enterprise system and to help make that system work. These programs include:

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— ***Workshops for High School Students:*** An intensive exploration of the American economic system as it relates to the student's life and future.

— ***Center for Business and Economic Education.*** Opened in 1964, the Center is an affiliate of the Joint Council on Economic Education and is involved in teacher education programs.

— ***Economics for the Professions.*** These programs address the special economic needs of specific professional groups, including journalists, physicians, dentists, and clergy.

— ***In-House Employee Economic Education Programs.*** These provide economic information and perspective for employees in relation to their roles as consumers, producers, and citizens.

— ***Publications:*** Newsletter, Chair of Private Enterprise History, Franklin Foundation Lecture Series, and occasional papers.

— ***Doctoral Fellowships:*** one in economics and one in business policy.

— ***Community Assistance Programs.*** These apply private enterprise principles to problems of downtown revitalization in small and middle-sized communities.

— ***A series of 12 discussions on*** economic issues on WGST Radio, 92 AM, which began November 16 and will be aired every other week for 6 months.

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This workshop is designed for young physicians planning to enter private practice and covers paperwork, patient management and public relations, personnel, physical characteristics of a medical office, "where and how," and legal problems.

Registration fee is $65 for members of a medical society; $100 for non-members. Spouses may audit at no charge (except $9 luncheon fee). Enrollment limited to first 25 registrants.

For further information and registration forms, contact Sue McAvoy at MAG, 876-7535 or (toll free) 800-282-0224

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Pfizer PHARMACEUTICALS

president's letter



Work, Stress, and Wednesdays

HOW OFTEN HAVE YOU HEARD the remark, "You can't get sick on Wednesdays because all the doctors are out fishing or playing golf"? Pretty often, right? Well, I say, God bless you, docs! You need a day off, and I'll tell you why.

George Sheehan, M.D., the physician marathoner, who is a cardiologist, says that the underlying cause of the epidemic of heart disease in the United States today is *too much work!* Like ulcers, colitis, and nervous breakdowns, coronary disease results from an overload on the physical, mental, or psychologic systems, or a combination of all three. Work is the real killer, Dr. Sheehan says.

Although work may be the main source of stress in a person's life, it is also, for most of us, the source of a substantial amount of satisfaction. For many of us, it is the primary source of the security, creativity, self expression, and self esteem that add value and purpose to our lives. Work, said Freud, is essential to mental health; it absorbs hostility and aggression. Work also satisfies our need to be with people, to participate in a worthwhile endeavor, and to contribute something of value to others.

Man's psychologic milieu is as much at issue as that miraculous balance of water and salts and hormones, the internal milieu. Man must have rest. The athlete knows that when stress is applied, the body must be given a chance to recuperate. The worker's stress is different, but aggravation, tension, and frustration definitely take their toll.

That's where Wednesday comes in. It is a day to adapt, a day to meditate. It is a day when we can surrender the heavy ladens of our work and refresh ourselves in spontaneous activity. Consider, for example, the physical, mental, and spiritual refreshment of a long-distance run, where your route is determined simply and spontaneously by your inner spirit, completely unfettered by external expectations and obligations. Whether it is in running, reading, writing, or just contemplating the sky, it is in, or as a result of, these times of free activity that we can discern what our jobs really mean and where they (and we) fit into the scheme of things. Wednesday is a day when, by separating ourselves from our involvement in the myriad aspects of our work and life, we can reclaim some of the toll exacted from us by our work.

So go ahead, do yourself and your patients a favor: take Wednesday (or at least half of it) off, and experience yourself!

Sincerely,

Carson B Burgstiner MD

Carson B. Burgstiner, M.D.
President, MAG

editorials
editorials
editorials

Divided We Fail or United We Conquer

ALMOST ALL of the 4,545 physicians who belong to the Medical Association of Georgia (MAG) also belong to their respective specialty society, such as the Georgia Chapter of the American Academy of Pediatrics, the Georgia Academy of Family Physicians, the Georgia Psychiatric Association, and so on. Most of the 25 specialty societies have approximately 250 members.

At some time, either in the past, currently, or in the near future, *your* specialty society will have a direct interest in a particular piece of legislation which will be voted on by the Georgia House of Representatives, with 180 members, and the Georgia Senate, with 56 members — all of whom represent Georgia's 159 counties and 5 million plus population. Their vote on the issue of most importance to you will most likely affect your medical practice and your patients.

Playing the old "Numbers Game," your specialty society, with perhaps 250 members, *is not* represented in the 152 Georgia counties which have medical doctors; therefore, the State Representatives and State Senators in those counties do not know who you are and what your interest is in the legislation. Likewise, if there is opposition to your viewpoint on the legislation, their membership might be between 200 and 500, and they are faced with the task of contacting 256 legislators. Your chances of success are looking rather flimsy, right? What is the solution?

MAG to the Rescue!!

Let MAG speak and work through its 4,545 membership on behalf of your (our) legislation. Pediatricians helping ophthalmologists helping family practitioners helping orthopedists, etc.

Alone, your chances may be 50-50, and you might win. With the cooperation of all, however, under the coordination of the membership of MAG, the "Numbers Game" is by far in *our* favor. Together, our chances are better. We have members in 152 of 159 counties, so our chances of success are greater.

James A. Kaufmann, M.D.
Chairman, MAG Legislative Committee

Life is of no value but as it brings us gratifications. Among the most valuable of these is rational society. It informs the mind, sweetens the temper, chears our spirits, and promotes health.

Thomas Jefferson [1743-1826]: Letter to James Madison, February 20, 1784.

The Flood of Mammography Scares

To gain recognition one must develop a new idea (nearly impossible), embellish a good one (difficult), or lambast a highly useful and popular one (foolproof). Mammography, the life-saving hope in the number one and most macabre cancer killer in women, has become an ideal target for the latter.

Critics of mammography found some eager syndicated columnists to spread unproven hypotheses about the dangers of mammography, even though these hypotheses were based on a 4-year-old evaluation of inadequate data. During this sensational and hysterical challenge to mammography, hordes of women, many with breast cancer, and physicians were scared away from the use of mammography.

Little attention was given to the fact that mammography has produced a revolution in early breast cancer detection and that not one case of breast cancer has actually resulted from mammography. What the critics had blown out of proportion was the hint that in 30 or more years those who have had a mammography may be at a small hypothetical risk. This concern was derived from a segment of 129,000 women less than 50 years of age being screened under the auspices of the American Cancer Society-National Cancer Institute Breast Cancer Detection Demonstration Project (BCDDP). This represented only one out of 2,000 potential breast cancer patients in the U.S.

Since tissue damage was noted when X-rays and radium were first used, radiologists and physicians have been cautious about determining the amount and intensity of radiation necessary for accurate diagnostic studies. Accordingly, the American College of Radiology has collaborated for decades with world authorities in determining radiologic units, standards, and protection, and only the minimum amount of radiation is used.

Oncologists who are familiar with breast cancer and who are involved with treatment of the disease strongly support mammography and recognize it as the most significant contribution to the treatment of the breast cancer patient since the introduction of the radical mastectomy near the turn of the century. It is the only way to detect preclinical breast cancer at an assuredly curable stage. It is interesting to note that oncologists are faced with treating a greater number of women with breast cancer per year in the United States than of Americans killed in 10 years of the Vietnamese war. It requires $\frac{1}{10}$ of the expense and $\frac{1}{10}$ of the work to cure a breast cancer patient than to care for a patient dying of the disease. Often the most vociferous critics of mammography have no experience or knowledge of the tremendous task of breast cancer treatment.

The referred, symptomatic breast cancer patients at Emory University were compared to the asymptomatic screenees with breast cancer of the Atlanta American Cancer Society-National Cancer Institute BCDDP. The results are shown in Table 1.

TABLE 1
COMPARISON OF SYMPTOMATIC AND ASYMPTOMATIC CANCER PATIENTS AT EMORY UNIVERSITY AND THE ATLANTA AMERICAN CANCER SOCIETY — NATIONAL CANCER INSTITUTE BCDPP

	Number of Patients	Age Under 59 Yrs.	Tumor Under 1 cm	Positive Axillary Nodes	Positive Mammograms	Average Size
BCDDP	132	37%	32%	31%	83%	1.2 cm
Emory	713	36%	36%	18%	91%	0.9 cm

The histological Stage 0 or Stage I cancers (82% above, Emory) approach 100% cure, a vast improvement over the 25% 10-year cure reported by Haagensen.[1] More recently, Urban[2] has reported a 95% 10-year cure rate in his series of cancers 1 cm or less in size, with most of these being found by mammography.

In the Vanderbilt University BCDDP, 34.2% of the cancers were non-infiltrating, while of those detected in the SEER program of that area, only 5.1% were non-infiltrating.

In 1,100 breast cancers in Georgia,[3] 80% were found by the patient, 15% by the physician, and 5% by mammography. Most cancers detected by other than mammography were advanced, pointing up the urgent need for early detection.

The maximum hypothetical risk of causing breast cancer by mammography can be illustrated by the mammographic technique at Emory University. The average exposure of 75 milliroentgens (mr) to the skin delivers 15 mr to the midpoint of the breast; then 30 mr is delivered for the two views during mammography. To increase this hypothetical risk of breast cancer from the national rate of 0.07 (1 in 14.28 females) to 0.0707 (1 in 14.14 females) requires 33⅓ mammograms, or to increase 1 %, from 0.07 to 0.08, requires 500 mammograms, and to double the risk, 0.07 to 0.14, requires 3,500 mammograms. To double the risk of breast cancer, at 20 minutes per examination, the woman would have to be x-rayed for 50 days and 50 nights. Noah's flood lasted only 40 days and 40 nights.

Robert L. Egan, M.D.
Professor of Radiology and
Chief, Mammography Section
Emory University, Atlanta

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2. Urban JA: Changing patterns of breast cancer. Cancer 37:111-117, 1976.
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Do you have patients currently taking oral contraceptives containing 100 mcg of estrogen for contraception? A switch to a 50 mcg product may be desirable.§

Prospective and retrospective studies indicate a relationship between estrogen doses and serious adverse side effects. ". . . preparations containing 100 mcg or more of estrogen were associated with a higher risk of thromboembolism. . ."† The incidence of these side effects decreases as the dosage of estrogen decreases to 50 mcg, as demonstrated in British studies.†

†See Prescribing Information.

a step in the right direction

Ortho-Novum 1/50 TRADEMARK

21 and 28-day regimens

Each yellow tablet contains 1 mg norethindrone and 0.05 mg mestranol.
Each green tablet in the 28-day regimen contains inert ingredients.

§Serious as well as minor side effects have been reported with the use of oral contraceptives. These include thromboembolic disease. The physician should remain alert to the earliest manifestations of any symptoms of serious disease and discontinue oral contraceptive therapy when appropriate. The physician should be fully aware of the complete Prescribing Information for this product.

See the complete Prescribing Information for this product, a summary of which is on the next page.

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ORTHO-NOVUM* Tablets

IMPORTANT NOTE—This informabon is a BRIEF SUMMARY of the complete prescribing information provided with the product and therefore should not be used as the basis for prescribing the product. This summery was prepared by deleting from the complete prescribing information certain text, tables, and references. The physician should be thoroughly familiar with the complete prescribing information end patient information before prescribing the product.

INOICATION: CONTRACEPTION. The pregnancy rate in women using conventional combination oral contraceptives (containing 35 mcg or more of ethinyl estradiol or 50 mcg or more of mestranol) is generally reported as less than one pregnancy per 100 woman-years of use. Slightly higher rates (somewhat more than one pregnancy per 100 woman-years of use) are reported for some combination products containing 35 mcg or less of ethinyl estradiol, and rates on the order of three pregnancies per 100 woman-years are reported for the progestogen-only oral contraceptives. Table 1 gives ranges of pregnancy rates reported in the literafure for other means of contraception. The efficacy of these means of contraception (except the IUD) depends upon the degree of adherence to the method.

Table 1: Pregnencies Per 100 Women-Years. IUD, less than 1-6; Oiaphragm with spermicidal product (creams or jellies), 2-20; Condom, 3-36; Aerosol foams, 2-29; Jellies and creams, 4-36; Periodic abstinence (rhythm) all types, less than 1-47; 1. Calendar method, 14-47; 2. Temperature method, 1-20; 3. Temperature method—intercourse only in postovulatory phase, less than 1-7; 4. Mucus method, 1-25; No contraception, 60-8D. **OOSE-RELATEO RISK OF THROMBOEMBOLISM FROM ORAL CONTRACEPTIVES:** Two studies have shown a positive association between the dose of estrogens in oral contraceptives and the risk of thromboembolism. For this reason, it is prudent and in keeping with good principles ot therapeutics to minimize exposure to estrogen. The oral contraceptive product prescribed for any given patient should be that product which contains the least amount of estrogen that is compatible with an acceptable pregnancy rate and patient acceptance. It is recommended that new acceptors of oral contraceptives be started on preparations containing .05 mg or less of estrogen.

CONTRAINDICATIONS: Oral contraceptives should not be used in women with any of the following conditions: 1. Thrombophlebitis or thromboembolic disorders. 2. A past history of deep vein thrombophlebitis or thromboembolic disorders. 3. Cerebral vascular or coronary artery disease. 4. Known or suspected carcinoma of the breast. 5. Known or suspected estrogen-dependent neoplasia. 6. Undiagnosed, abnormal genital bleeding. 7. Known or suspected pregnancy (see WARNINGS, No. 5).

WARNINGS

Cigarette smoking increases the risk of serious cardiovascular side effects from oral contraceptive use. This risk increases with age and with heavy smoking (15 or more cigarettes per day) and is quite marked in women over 35 years of age. Women who use oral contraceptives should be strongly advised not to smoke.

The use of oral contraceplives is associated with increased risk ot several serious conditions including thromboembolism, stroke, myocardial inferction, hepatic adenoma, gallbladder disease, hypertension. Practitioners prescribing oral contraceptives should be familiar with the following information relating to these risks.

1. THROMBOEMBOLIC OISORDERS AND OTHER VASCULAR PRDBLEMS. An increased risk of thromboembolic and thrombotic disease associated with the use of oral contraceptives is well established. Four principal studies in Great Britain and three in the United States have demonstrated an increased risk of fatal and nonfatal venous thromboembolism and stroke, both hemorrhagic and thrombotic. These studies estimate that users of oral contraceptives are 4 to 11 times more likely than nonusers to develop these diseases without evident cause. Overall excess mortality due to pulmonary embolism or stroke is on the order of 1.0 to 3.5 deaths annually per 1DD,OOD users and increases with age. **CEREBROVASCULAR DISORDERS:** In a collaborative American sfudy of cerebrovascular disorders in women with and without predisposing causes, it was estimated that the risk of hemorrhagic stroke was 2.D times greater in users than in nonusers and the risk of thrombotic stroke was 4.0 to 9.5 times greater in users than in nonusers.

MYOCAROIAL INFARCTION: An increased risk of myocardial infarction associated with the use of oral contraceptives has been reported confirming a previously suspected association. These studies, conducted in the United Kingdom, found, as expected, that the greater the number of underlying risk factors for coronary artery disease (cigarette smoking, hypertension, hypercholesterolemia, obesity, diabetes, history of preeclamptic toxemia), the higher the risk of developing myocardial infarction, regardless of whether the patient was an oral contraceptive user or not. Oral contraceptives, however, were found to be a clear additional risk factor. The annual excess case rate (increased risk) of myocardial infarction (fatal and nonfatal) in oral contraceptive users was estimated to be approximately 7 cases per 1DD,DOD women users in the 30-39 age group and 67 cases per 100,000 women users in the 40-44 age group. In terms of relative risk, it has been estimated that oral contraceptive users who do not smoke (smoking is considered a major predisposing condition to myocardial infarction) are about twice as likely to have a fatal myocardial infarction as nonusers who do not smoke. Oral contraceptive users who are also smokers have about a 5-fold increased risk of fatal infarction compared to users who do not smoke, but about a 10-to 12-fold increased risk compared to nonusers who do not smoke. Furthermore, the amount of smoking is also an important factor. In determining the importance of these relative risks, however, the baseline rates for various age groups must be given serious consideration. The importance of other predisposing conditions mentioned above in determining relative and absolute risks has not as yet been quantified; it is quite likely that the same synergistic action exists, but perhaps to a lesser extent. **Risk of Oose:** In an analysis of data derived from several national adverse reaction reporting systems, British investigators concluded that the risk of thromboembolism including coronary thrombosis is directly related to the dose of estrogen used in oral contraceptives. Preparations containing 100 mcg or more of estrogen were associated with a higher risk of thromboembolism than those containing 5D-8D mcg of estrogen. Their analysis did suggest, however, that the quantity of estrogen may not be the sole factor involved. This finding has been confirmed in the United States. Careful epidemiological studies to determine the degree of thromboembolic risk associated with progestogen-only oral contraceptives have not been pertormed. Cases of thromboembolic disease have been reported in women using these products, and they should not be presumed to be free of excess risk. The risk of thromboembolic and thrombotic disorders, in both users and nonusers of oral contraceptives, increases with age. Oral contraceptives are, however, an independent risk factor for these events. **ESTIMATE OF EXCESS MORTALITY FROM CIRCULATORY DISEASES:** A large prospective study carried out in the United Kingdom estimated the mortality rate per 100,000 women per year from diseases of the circulatory system for users and nonusers of oral contraceptives according to age, smoking habits, and duration of use. The overall excess death rate annually from circulatory diseases for oral contraceptive users was estimated to be 20 per 100,D0D (ages 15-34—5/1DD,D0D; ages 35-44—33/100,000; ages 45-49—140/100,000), the risk being concentrated in older women, in those with a long duration of use, and in cigarette smokers. It was not possible, however, to examine the interrelationships of age, smoking, and duration of use, nor to compare the effects of continuous versus intermittent use. Although the study showed a 1D-fold increase in death due to circulatory diseases in users for five or more years, all of these deaths occurred in women 35 or older. Until larger numbers of women under 35 with continuous use for five or more years are available, it is not possible to assess the magnitude of the relative risk for this younger age group. This study reports that the increased risk of circulatory diseases may persist after the pill is discontinued. Another study published at the same time confirms a previously reported increase of mortality in pill users from cardiovascular disease. The available data from a variety of sources have been analyzed to estimate the risk of death associated with various methods of contraception. The estimates of risk of death for each method include the combined risk of the contraceptive method (e.g., thromboembolic and thrombotic disease in the case of oral contraceptives) plus the risk attributable to pregnancy or abortion in the event of method failure. This latter risk varies with the effectiveness of the contraceptive method. The findings of this analysis are shown in Figure 1 below. The study concluded that the mortality associated with all methods ot birth control is low and below that associated with childbirth, with the exception of oral contraceptives in women over 4D who smoke. (The rates given for pill only/smokers for each age group are for smokers as a class. For "heavy" smokers [more than 15 cigarettes a day], the rates given would be about double; for "light" smokers [less than 15 cigarettes a day], about 5D percent.) The mortality associated with oral contraceptive use in nonsmokers over 4D is higher than with any other method of contraception in that age group. The lowest mortality is associated with the condom or diaphragm backed up by early abortion. The risk of thromboembolic and thrombotic disease associated with oral contraceptives increases with age after approximately age 30 and, for myocardial infarction, is further increased by hypertension, hypercholesterolemia, obesity, diabetes, or history ot preeclamptic toxemia and especially by cigarette smoking. The risk of myocardial infarction in oral contraceptive users is substantially increased in women age 40 and over, especially those with other risk factors. The use of oral contraceptives in women in this age group is not recommended. Based on the data currently available, the following chart gives a gross estimate of the risk of death from circulatory disorders associated with the use of oral contraceptives:

SMOKING HABITS ANO OTHER PREOISPOSING CONOITIONS—RISK ASSOCIATED WITH USE OF ORAL CONTRACEPTIVES

Age	Below 3D	3D-39	40+	
Heavy smokers	C	B	A	A—Use associated with very high risk.
Light smokers	D	C	B	B—Use associated with high risk.
Nonsmokers (no predisposing conditions)	D	C,0	C	C—Use associated with moderate risk.
Nonsmokers (other predisposing conditions)	C	C,B	B,A	0—Use associated with low risk.

The physician and the patient should be alert to the earliest manifestations of thromboembolic and thrombotic disorders (e.g., thrombophlebitis, pulmonary embolism, cerebrovascular insufficiency, coronary occlusion, retinal thrombosis, and mesenteric thrombosis). Should any of these occur or be suspected, the drug should be discontinued immediately. A four- to six-fold increased risk of postsurgery thromboembolic complications has been reported in oral contraceptive users. If feasible, oral contraceptives should be discontinued at least four weeks before surgery of a type associated with an increased risk of thromboembolism or prolonged immobilization. 2. OCULAR LESIDNS. There have been reports of neuro-ocular lesions such as optic neuritis or retinal thrombosis associated with the use of oral contraceptives. Oiscontinue oral contraceptive medication it there is unexplained, sudden or gradual, partial or complete loss of vision; onset of proptosis or diplopia; papilledema; or retinal vascular lesions and institute appropriate diagnostic and therapeutic measures. 3. CARCINOMA. Long-term continuous administration of either natural or synthetic estrogen in certain animal species increases the frequency of carcinoma of the breast, cervix, vagina, and liver. Certain synthetic progestogens, none currently contained in oral contraceptives, have been noted to increase the incidence of mammary nodules, benign and malignant, in dogs. In humans, three case control studies have reported an increased risk of endometrial carcinoma associated with the prolonged use of exogenous estrogen in postmenopausal women. One publication reported on the first 21 cases submitted by physicians to a registry of cases of adenocarcinoma of the endometrium in women under 40 on oral contraceptives. Of the cases found in women without predisposing risk factors for adenocarcinoma of the endometrium (e.g., irregular bleeding at the time oral contraceptives were tirst given, polycystic ovaries), nearly all occurred in women who had used a sequential oral contraceptive. These products are no longer marketed. No evidence has been reported suggesting an increased risk of endometrial cancer in users of conventional combination or progestogen-only oral contraceptives. Several studies have found no increases in breast cancer in women taking oral contraceptives or estrogens. One study, however, while also noting no overall increased risk of breast cancer in women treated with oral contraceptives, found an excess risk in the subgroups of oral contraceptive users with documented benign breast disease. A reduced occurrence of benign breast tumors in users of oral contraceptives has been well-documented. In summary, there is at present no confirmed evidence from human studies of an increased risk of cancer associated with oral contraceptives. Close clinical surveillance of all women taking oral contraceptives is, nevertheless, essential. In all cases of undiagnosed persistent or recurrent abnormal vaginal bleeding, appropriate diagnostic measures should be taken to rule out malignancy. Women with a strong family history of breast cancer or who have breast nodules, fibrocystic disease or abnormal mammograms should be monitored with particular care if they elect to use oral contraceptives instead ot other methods of contraception.

Figure 1. Estimated annual number ot deaths associated with control of fertility and no control per 100,00D nonsterile women, by regimen of control and age of woman.

	15-19	20-24	25-29	30-34	35-39	40-44
No method	5.5	5.2	7.1	14.0	19.3	21.9
Abortion only	2.3	2.5	2.5	5.2	9.8	6.6
Pill only-nonsmokers	1.3	1.4	1.4	2.2	4.5	3.1
Pill only-smokers	1.5	1.6	1.6	10.8	13.4	58.9
IUOs only	1.1	1.2	1.2	1.4	1.6	1.4
Traditional contraception only	1.1	1.4	1.9	3.7	4.7	4.0
Traditional contraception and abortion	D.3	0.4	D.4	D.8	1.4	0.8

4. HEPATIC TUMORS. Benign hepatic adenomas have been found to be associated with the use of oral contraceptives. One study showed that oral contraceptive formulations with high hormonal potency were associated with a higher risk than lower potency formulations. Although benign, hepatic adenomas may rupture and may cause death through intra-abdominal hemorrhage. This has been reported in short-term as well as long-term users of oral contraceptives. Two studies relate risk with duration of use of the contraceptive, the risk being much greater after four or more years of oral contraceptive use. While hepatic adenoma is a rare lesion, it should be considered in women presenting abdominal pain and tenderness, abdominal mass or shock. A few cases of hepatocellular carcinoma have been reported in women taking oral contraceptives. The relationship of these drugs to this type of malignancy is not known at this time. 5. USE IN OR IMMEOIATELY PRECEDING PREGNANCY, BIRTH DEFECTS IN OFFSPRING, AND MALIGNANCY IN FEMALE OFFSPRING. The use of female sex hormones—both estrogenic and progestational agents—during early pregnancy may seriously damage the offspring. It has been shown that females exposed in utero to diethylstilbestrol, a nonsteroidal estrogen, have an increased risk of developing in later life a form of vaginal or cervical cancer that is ordinarily extremely rare. This risk has been estimated to be on the order of 1 to 4 in 1000 exposures. Although there is no evidence at the present time that oral contraceptives further enhance the risk of developing this type of malignancy, such patients should be monitored with particular care if they elect to use oral contraceptives instead of other methods of contraception. Furthermore, a high percentage of such exposed women (from 30 to 90%) have been found to have epithelial changes of the vagina and cervix. Although these changes are histologically benign, it is not known whether this condition is a precursor of vaginal malignancy. Male children so exposed may develop abnormalities of the urogenital tract. Although similar data are not available with the use of other estrogens, it cannot be presumed that they would not induce similar changes. An increased risk of congenital anomalies, including heart defects and limb defects, has been reported with the use of sex hormones, including oral contraceptives, in pregnancy. One case control study has estimated a 4.7-fold increase in risk of limb-reduction defects in infants exposed in utero to sex hormones (oral contraceptives, hormonal withdrawal tests for pregnancy or attempted treatment for threatened abortion). Some of these exposures were very short and involved only a few days of treatment. The data suggest that the risk of limb-reduction defects in exposed fetuses is somewhat less than one in 1,000 live births. In the past, female sex hormones have been used during pregnancy in an attempt to treat threatened or habitual abortion. There is considerable evidence that estrogens are ineffective for these indications, and there is no evidence from well-controlled studies that progestogens are effective for these uses. There is some evidence that triploidy and possibly other types of polyploidy are increased among abortuses from women who become pregnant soon after ceasing oral contraceptives. Embryos with these anomalies are virtually always aborted spontaneously. Whether there is an overall increase in spontaneous abortion of pregnancies conceived soon after stopping oral contraceptives is unknown. Pregnancy should be ruled out before initiating or continuing the contraceptive regimen. Pregnancy should always be considered if withdrawal bleeding does not occur. If pregnancy is confirmed, the patient should be apprised of the potential risks to the fetus and the advisability of continuation of the pregnancy should be discussed in the light of these risks. It is also recommended that women who discontinue oral contraceptives with the intent ot becoming pregnant use an alternate form of contraception for a period of time before attempting to conceive. Many clinicians recommend three months although no precise information is available on which to base this recommendation. The administration of progestogen-only or progestogen-estrogen combinations to induce withdrawal bleeding should not be used as a test of pregnancy. 6. GALLBLADDER DISEASE. Studies report an increased risk of surgically confirmed gallbladder disease in users ot oral contraceptives and estrogens. In one study, an increased risk appeared after two years of use and doubled after four or tive years of use. In one of the other studies, an increased risk was apparent between six and twelve months of use. 7. CARBOHYDRATE AND LIPIO METABOLIC EFFECTS. A decrease in glucose tolerance has been observed in a significant percentage of patients on oral contraceptives. For this reason, prediabetic and diabetic patients should be carefully observed while receiving oral contraceptives. An increase in triglycerides and total phospholipids has been observed in patients receiving oral contraceptives. 8. ELEVATED BLOOD PRESSURE. An increase in blood pressure has been reported in patients receiving oral contraceptives. In some women hypertension may occur within a few months of beginning oral contraceptive use. In the first year of use, the prevalence of women with hypertension is low in users and may be no higher than that of a comparable group of nonusers. The prevalence in users increases, however, with longer exposure, and in the fifth year of use is two and a half to three times the reported prevalence in the first year. Age is also strongly correlated with the development of hypertension in oral contraceptive users. Women who previously have had hypertension during pregnancy may be more likely to develop elevation of blood pressure when given oral contraceptives. Hypertension that develops as a result of taking oral contraceptives usually returns to normal after discontinuing the drug. 9. HEADACHE. The onset or exacerbation of migraine or development of headache of a new pattern which is recurrent, persistent, or severe, requires discontinuation of oral contraceptives and evaluation of the cause. 10. BLEEDING IRREGULARITIES. Breakthrough bleeding, spotting, and amenorrhea are frequent reasons for patients discontinuing oral contraceptives. In breakthrough bleeding, as in all cases of irregular bleeding from the vagina, nonfunctional causes should be borne in mind. In undiagnosed persistent or recurrent abnormal bleeding from the vagina, adequate diagnostic measures are indicated to rule out pregnancy or malignancy. If pathology has been excluded, time or a change to another formulation may solve the problem. Changing to an oral contraceptive with a higher estrogen content, while potentially useful in minimizing menstrual irregularity, should be done only if necessary since this may increase the risk of thromboembolic disease. Women with a past history of oligomenorrhea or secondary amenorrhea or young women without regular cycles may have a tendency to remain anovulatory or to become amenorrheic after discontinuation of oral contraceptives. Women with these preexisting problems should be advised of this possibility and encouraged to use other contraceptive methods. Postuse anovulation, possibly prolonged, may also occur in women without previous irregularities. 11. ECTOPIC PREGNANCY. Ectopic as well as intrauterine pregnancy may occur in contraceptive failures. 12. BREAST FEEDING. Oral contraceptives given in the postpartum period may intertere with lactation. There may be a decrease in the quantity and quality of the breast milk. Furthermore, a small fraction of the hormonal agents in oral contraceptives has been identified in the milk of mothers receiving these drugs. The effects, if any, on the breast-fed child have not been determined. If feasible, the use ot oral contraceptives should be deferred until the infant has been weaned. **PRECAUTIONS: General:** 1. A complete medical and family history should be taken prior to the initiation of oral contraceptives. The pretreatment and periodic physical examinations should include special reference to blood pressure, breasts, abdomen and pelvic organs, including Papanicolaou smear and relevant laboratory tests. As a general rule, oral contraceptives should not be prescribed for longer than one year without another physical examination being pertormed. 2. Under the influence of estrogen-progestogen preparations, preexisting uterine leiomyomata may increase in size. 3. Patients with a history of psychic depression should be carefully observed and the drug discontinued if depression recurs to a serious degree. Patients becoming significantly depressed while taking oral contraceptives should stop the medication and use an alternate method of contraception in an attempt to determine whether the symptom is drug-related. 4. Oral contraceptives may cause some degree of fluid retention. They should be prescribed with caution, and only with careful monitoring, in patients with conditions which might be aggravated by fluid retention, such as convulsive disorders, migraine syndrome, asthma, or cardiac or renal insufficiency. 5. Patients with a past history of jaundice during pregnancy have an increased risk of recurrence of jaundice while receiving oral contraceptive therapy. If jaundice develops in any patient receiving such drugs, the medication should be discontinued. 6. Steroid hormones may be poorly metabolized in patients with impaired liver function and should be administered with caution in such patients. 7. Oral contraceptive users may have disturbances in normal tryptophan metabolism which may result in a relative pyridoxine deficiency. 8. Serum folate levels may be depressed by oral contraceptive therapy. Since the pregnant woman is predisposed to the development of folate deficiency and the incidence of folate deficiency increases with increasing gestation, it is possible that if a woman becomes pregnant shortly after stopping oral contraceptives, she may have a greater chance of developing folate deficiency and complications attributed to this deficiency. 9. The pathologist should be advised of oral contraceptive therapy when relevant specimens are submitted. 1D. Certain endocrine and liver function tests and blood components may be affected by estrogen-containing oral contraceptives: a. Increased sulfobromophthalein retention. b. Increased prothrombin and factors VII, VIII, IX, and X; decreased antithrombin 3; increased norepinephrine-induced platelet aggregability. c. Increased thyroid-binding globulin (TBG) leading to increased circulating total thyroid hormone, as measured by protein-bound iodine (PBI), T4 by column, or T4 by radioimmunoassay. Free T3 resin uptake is decreased, reflecting the elevated TBG, free T4 concentration is unaltered. d. Decreased pregnanediol excretion. e. Reduced response to metyrapone test. **INFORMATION FOR THE PATIENT: (See Patient Package Insert). ORUG INTERACTIONS:** Reduced efficacy and increased incidence of breakthrough bleeding have been associated with concomitant use of rifampin. A similar association has been suggested with barbiturates, phenylbutazone, phenytoin sodium, and ampicillin. **CARCINOGENESIS, PREGNANCY, NURSING MOTHERS: See CONTRAINOICATIONS and WARNINGS. ADVERSE REACTIONS:** An increased risk of the following serious adverse reactions has been associated with the use ot oral contraceptives (see WARNINGS): Thrombophlebitis. Pulmonary embolism. Coronary thrombosis. Cerebral thrombosis. Cerebral hemorrhage. Hypertension. Gallbladder disease. Liver tumors. Congenital anomalies. There is evidence of an association between the following conditions and the use of oral contraceptives, although additional confirmatory studies are needed: Mesenteric thrombosis. Neuro-ocular lesions, e.g., retinal thrombosis and optic neuritis. The following adverse reactions have been reported in patients receiving oral contraceptives and are believed to be drug-related: Nausea, usually the most common adverse reaction. Vomiting, occurs in approximately 10% or less of patients during the tirst cycle. Other reactions, as a general rule, are seen much less frequently or only occasionally. Gastrointestinal symptoms (such as abdominal cramps and bloating). Breakthrough bleeding. Spotting. Change in menstrual flow. Dysmenorrhea. Amenorrhea during and after treatment. Temporary infertility after discontinuance of treatment. Edema. Chloasma or melasma which may persist. Breast changes: tenderness, enlargement, and secretion. Change in weight (increase or decrease). Change in cervical erosion and cervical secretion. Possible diminution in lactation when given immediately postpartum. Cholestatic jaundice. Migraine. Increase in size of uterine leiomyomata. Rash (allergic). Mental depression. Reduced tolerance to carbohydrates. Vaginal candidiasis. Change in corneal curvature (steepening). Intolerance to contact lenses. The following adverse reactions have been reported in users ot oral contraceptives, and the association has been neither confirmed nor refuted: Premenstrual-like syndrome. Cataracts. Changes in libido. Chorea. Changes in appetite. Cystitis-like syndrome. Headache. Nervousness. Dizziness. Hirsutism. Loss of scalp hair. Erythema multiforme. Erythema nodosum. Hemorrhagic eruption. Vaginitis. Porphyria. Impaired renal function. (ORTHO-NOVUM 1/50□21 and ORTHO-NOVUM 1/50□28 contain tartrazine. Allergic reactions have been reported with the ingestion of this dye in some patients.) **ACUTE OVEROOSE:** Serious ill effects have not been reported following acute ingestion of large doses of oral contraceptives by young children. Overdosage may cause nausea, and withdrawal bleeding may occur in females.

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Disposition of a Deceased Physician's Patient Records

ROBERT N. BERG, *Atlanta**

ONE OF THE NECESSARY adjuncts to the practice of medicine is the compilation of patient information — personal profiles, medical histories, physical examination results, laboratory reports, x-ray reports, consultation reports, operation records, signed consent forms, and so on. In most cases, the physician compiles and maintains his or her patient records without giving much thought to the question of what will happen to these records when the physician ceases to practice; this decision is usually deferred until such time as the physician begins contemplating retirement. Should the physician die prior to retirement, however, the deceased physician's family or the executor of his or her estate will be faced with the complex problem of determining what to do with his or her patient records. Should they be destroyed? Should they be transferred to another physician? Should they be retained, and, if so, for how long?

Destruction of Patient Records

Although there is little case law dealing with the question of ownership of medical records, the state of the law at the present time appears to be that medical records are the property of the physician rather than the patient.[1] Consequently, one alternative which would be available to the deceased physician's family or executor would simply be to destroy the patient records. This alternative is not satisfactory, however, for both legal and practical reasons.

Initially, the patients of a deceased physician may have a legal right to prevent the destruction of their medical records. For example, in the New York case of *In re Culbertson's Will,*[2] a physician provided in his will that all of his professional records should be destroyed. Upon his death, several of his patients brought a suit to enjoin the destruction of the medical records pertaining to them and to have these records transferred to their new physicians. The Court held that, as a matter of law, the records were the property of the physician and therefore belonged to his estate and not to his patients. Nevertheless, in light of the AMA *Principles of Medical Ethics* and certain opinions of the AMA Judicial Council with regard to the ethical obligations placed upon a physician to cooperate with the physician who succeeds him in caring for his patients, the Court held that it would be against public policy to allow the estate to destroy the patients' records.

The destruction of patient records upon the death of the attending physician is also unsatisfactory for several practical reasons. While patient records are normally maintained by the physician primarily for the purpose of assisting him or her in the diagnosis and treatment of the patient, the information contained in these records may be vital to the later treatment of the patient by a different physician, or may be useful to the patient in connection with a wide variety of matters ranging from qualifying for life insurance policies or new jobs to prosecuting or defending a claim for personal injuries resulting from an accident. Moreover, the destruction of patient records may be a disservice to the deceased physician's family or executor, in that the records may be extremely important to the defense of a malpractice claim brought subsequent to the physician's death.

* Prepared at the request of the Medical Association of Georgia (MAG). Mr. Berg is an associate in the firm of Powell, Goldstein, Frazer, & Murphy, General Counsel to MAG, 1100 C & S National Bank Building, Atlanta, Ga. 30303.

Transfer of Patient Records

A second alternative available to the deceased physician's family or executor, and the one most often utilized in connection with the disposition of patient records, would be to transfer the patient records to another physician. This alternative can be a trap for the unwary, however, if the proper steps are not taken to effectuate the transfer.

As previously pointed out, the patient records are the property of the physician. Nevertheless, these records contain confidential information which, if disclosed without the proper authorization, could result in an unwarranted invasion of the patient's right of privacy.[3] Consequently, to alleviate this possibility, it would be necessary for the deceased physician's family or executor to notify each of the deceased physician's patients and obtain their authorized consent, in writing, before the records pertaining to them could be transferred to another physician.

In the normal situation, the patient will authorize the deceased physician's family or executor to transfer that patient's records to the physician who will succeed the deceased physician in treating that patient. Conversely, there may be situations in which the patient refuses to authorize the transfer of his or her records to another physician. In these situations, the deceased physician's family or executor should not under any circumstances transfer that patient's records to another physician.

Retention of Patient Records

If the deceased physician's patient records cannot be destroyed, and if that physician's patients do not authorize the transfer of the records to another physician, these records must be retained — but for how long? Ideally, the records should be retained for as long as the patient lives, but this is unrealistic in light of the problem of limited storage space and the costs involved.

Alternatively, it has often been suggested that the key factor to be considered in determining the appropriate length of time for retaining patient records is the statute of limitations governing the institution of malpractice claims. The reasoning behind this suggestion is that, by retaining a patient's records until such time as the patient is barred from bringing a malpractice claim, the deceased physician's family or executor is protected against the situation, referred to above, wherein the family or executor does not have the medical records necessary to defend the malpractice claim.

The problem with this reasoning is that the statutory period within which malpractice claims may be instituted is not, in all situations, a fixed period. For example, the general rule in Georgia is that an action for medical malpractice must be brought within 2 years of the date on which the negligent or wrongful act or omission occurred.[4] In the case of minors, however, this 2-year period does not begin to run until the minor reaches the age of majority. Thus, it is possible that a malpractice action may legally be brought as many as 20 years after the negligent or wrongful act occurred.[5]

In addition, in malpractice claims involving allegations that foreign objects were left in the body of a patient during surgery, the action must be brought within 1 year following the discovery of the foreign object.[6] While, in most cases, this exception to the general 2-year statute of limitations serves to shorten the time within which an action may be brought, it is conceivable that a patient may not discover the foreign object for several years following the alleged act of malpractice.

In total, there is no blanket rule for determining the length of time that patient records should be retained. The deceased physician's family or executor must make this decision on a case-by-case basis, balancing the costs involved in retaining the records against the risks involved in destroying the records and thereafter having to defend malpractice claims without them.

Notes

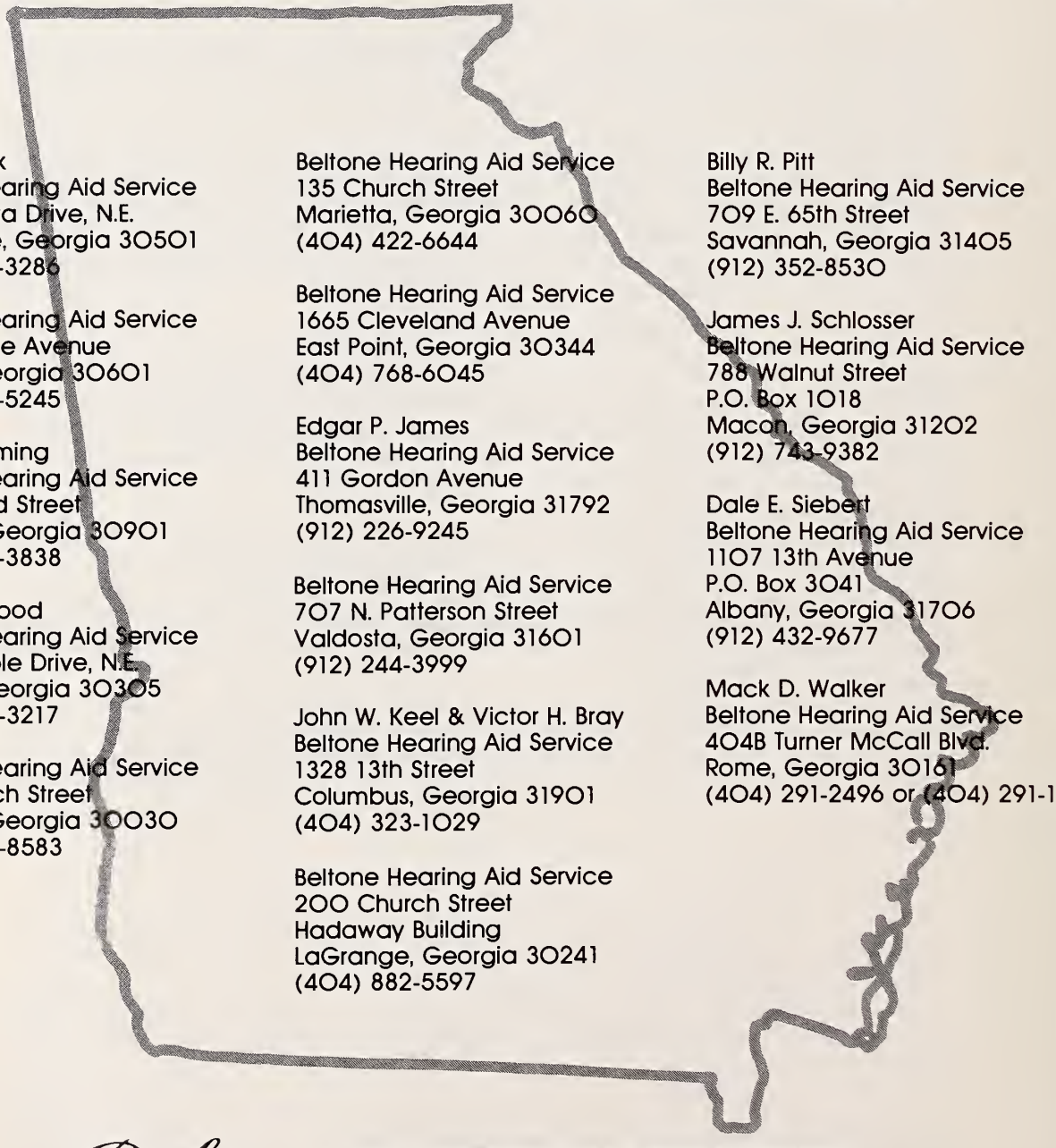
1. See, e.g. *Gotkin v. Miller*, 379 F.Supp. 859 (E.D.N.Y. 1974); AMA Opinions and Reports of Judicial Council, Section 5.62.
2. 57 Misc. 2d 391, 292 N.Y.S.2d 806 (1968).
3. Although there is no specific statutory right of privacy in Georgia, *Ga. Code Ann.* §40-2703 suggests that the disclosure of confidential information in medical records would be an unwarranted invasion of personal privacy.
4. *Ga. Code Ann.* §3-1102.
5. See, e.g. *Bettigole v. Diener*, 124 A.2d 265 (Ct. of App. Md. 1956), where the plaintiff, age 24, alleged that the defendant physician had been negligent in performing an operation on the plaintiff when the plaintiff was 7 years old.
6. *Ga. Code Ann.* §3-1103.

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Counseling the Adult with Congenital Heart Disease

DOROTHY BRINSFIELD, M.D., *Atlanta**

RECENT ADVANCES in the diagnosis, medical management, and surgical correction of congenital heart disease in infants and children have resulted in an increased number of adults who have had serious cardiac anomalies repaired surgically. Also, many children with inoperable heart disease now survive to adult life because of successful surgical palliation and prevention of the complications of congenital heart disease. In the future, the obstetrician, internist, and family physician will be faced with advising these young cardiac patients who wish to make plans for their families. The patient population is becoming better informed, and patients have gained enough insight to ask questions and to expect to participate in the decision-making process.

The level of knowledge concerned with the diagnosis, treatment, and prevention of human genetic disorders has increased dramatically in recent years. Numerous articles have appeared, listing specific risk factors of recurrent cardiac anomalies and syndromes associated with cardiac defects. The list of recognizable syndromes grows longer each year, and textbooks describing these syndromes have multiplied accordingly. Surely there must be a concise and efficient method for the primary care physician to use in counseling patients regarding the genetic and familial inheritance of cardiac anomalies.

The first and most important step is to obtain a detailed and complete family history, including that of first and second degree relatives, of known cardiac anomalies, "disappearing" heart murmurs (which may represent spontaneous closure of a cardiac defect), unusual facies or stature, and spontaneous abortions which carry a high incidence of anomalies. A history of the pregnancy of the patient's mother should specifically question the possibility of exposure to rubella and other viral infections and to alcohol or drugs during the pregnancy. The possibility of maternal diabetes mellitus or lupus erythematosis should also be considered. A complete physical examination of the affected adult, with special attention to unusual features, is essential. Several questions should be answered. Are there one, two, or more first degree relatives with a possible congenital heart defect? Are there unusual features, such as webbed neck, finger-like thumb, short or tall stature, mental retardation, pie-bald lock of hair, or low-set ears to suggest the possibility of a chromosomal abnormality or a single gene mutant? Was there an environmental infection, drug exposure, or maternal condition during the pregnancy of the affected adult?

* Dr. Brinsfield is a professor of pediatrics in cardiology and Executive Associate Dean at Emory University School of Medicine. Her address is 1440 Clifton Rd., NE, Atlanta, GA 30322. Articles for this page are prepared at the request of the Physician Education Committee of the Georgia Heart Association, Broadview Plaza, Level C, 2581 Piedmont Rd., NE, Atlanta, GA 30324.

The second step is to review the known etiologies of congenital heart disease carefully before counseling the patient or deciding that a consultation with a geneticist is advisable; primary genetic factors constitute 8%, environmental factors 2%, and multifactorial interaction 90% of the etiologies. Of the genetic factors, 5% are chromosomal abnormalities and 3% single gene mutant. Studies have failed to demonstrate chromosomal anomalies in patients with congenital heart disease unless the defect was part of a syndrome. Examples of chromosomal disorders with congenital heart disease are Down's Syndrome, 13 and 18 trisomies, Cat-eye Syndrome, Cri-du-chat (cry of the cat) Syndrome, Turner's Syndrome, and XXXXY male. Clearly, individuals with any of these chromosomal disorders would be easily recognized because of multiple associated anomalies. Therefore, if the affected adult or a first degree relative has any unusual feature suggesting a syndrome, consultation with a geneticist is strongly recommended, and amniocentesis may be considered in specific situations.

Examples of single gene mutants may be more difficult to recognize, and the inheritance pattern may be autosomal dominant or recessive. The incidence of cardiac anomalies in single gene mutant varies between 5 and 99% when the inheritance is autosomal dominant, and between 15 and 100% when the inheritance is autosomal recessive. In autosomal dominant inheritance patterns, the syndrome in one parent indicates 50% of the offspring will be affected, and unaffected siblings cannot transmit the syndrome. In autosomal recessive inheritance, one affected parent will produce no affected offspring, but it will produce 100% carriers. If both parents are carriers, 25% of the offspring will be affected, and 50% will be carriers. Syndromes due to autosomal dominant single mutant genes are: Barlow, Ehlers-Danlos, Holt-Oram, Marfan, Noonan, Teacher-Collins, Williams, and others. Syndromes due to autosomal recessive single mutant genes are: Ellis-van Creveld, Friedreich ataxia, Ivemark, mucopolysaccharidosis and others. Fortunately, X-linked single mutant gene anomalies are rare, but they have a dominant and recessive mode of transmission. Again, the unusual features and the associated anomalies found in the affected adult, or in the first or second degree relatives, should raise the possibility of a genetic disorder as the etiology of the congenital heart defects. Consultation with a geneticist is recommended to determine the exact inheritance pattern and recurrence risk.

Environmental factors, which constitute 2% of the etiologies, include rubella and other viral infections, maternal conditions (such as diabetes mellitus and lupus erythematosis), and alcohol and drug ingestion during pregnancy. The vulnerable period of cardiogenesis is usually between the 14th and 60th day of gestation. Rubella infection can be avoided by proper counseling and immunizations prior to conception. Other viral infections which are highly suspected as a cause of cardiac anomalies are more difficult to avoid. It has been suggested that a woman at high risk of producing offspring with congenital anomalies should avoid working or social conditions that expose her to viral infections during the first trimester of pregnancy.

Cardiovascular teratogens need special emphasis since many, but not all, can be avoided during pregnancy. Among the teratogens which have been incriminated are alcohol, amphetamines, hydantoin, lithium, progesterone, estrogen, thalidamide, and trimethadione. Since other drugs may also influence fetal development, the adult cardiac patient should be given no drug therapy during pregnancy unless it is vitally necessary.

Multifactorial interaction is considered the etiology in 90% of patients with congenital heart disease. This category is not a vague grouping of unknowns but is clearly defined as the hereditary predisposition to cardiovascular maldevelopment which interacts with an environmental trigger (virus or drug) at a vulnerable period of cardiogenesis. If the adult cardiac patient is the only patient in the family with a cardiac defect, and there are no first degree relatives with congenital heart disease, the recurrence risk is 1 to 5% in the offspring. The more common the heart defect is, such as ventricular septal defect, the more likely it is to recur. The

addition of an environmental insult to the fetus shifts the cardiac malformation threshold to a lower level, and a larger number of offspring, 15 to 25%, may have cardiac anomalies. If the affected parent has two or more relatives with congenital cardiac anomalies, 50% or more of the offspring will have congenital heart disease.

After reviewing the complete data base, the primary care physician should discuss these recurrence risks with the adult cardiac patient and gain the cooperation of the family in avoiding environmental teratogens. If multiple first degree relatives have cardiac anomalies, pregnancy should be avoided in most cases. Is it not better that we attempt to prevent congenital heart disease than to continue to put primary emphasis on salvaging infants with cardiac defects who will mature and produce offspring with an increased risk of cardiac anomalies? Therein lies the problem. It is important that all primary care physicians keep abreast of new and important developments in genetics in the hope of avoiding the tremendous emotional and financial stress on the families of surviving infants with congenital anomalies.

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WARNINGS: If tolerance develops, the recommended dose should not be exceeded in an attempt to increase the effect; rather, the drug should be discontinued. Tenuate may impair the ability of the patient to engage in potentially hazardous activities such as operating machinery or driving a motor vehicle; the patient should therefore be cautioned accordingly. *Drug Dependence*: Tenuate has some chemical and pharmacologic similarities to the amphetamines and other related stimulant drugs that have been extensively abused. There have been reports of subjects becoming psychologically dependent on diethylpropion. The possibility of abuse should be kept in mind when evaluating the desirability of including a drug as part of a weight reduction program. Abuse of amphetamines and related drugs may be associated with varying degrees of psychologic dependence and social dysfunction which, in the case of certain drugs, may be severe. There are reports of patients who have increased the dosage to many times that recommended. Abrupt cessation following prolonged high dosage administration results in extreme fatigue and mental depression; changes are also noted on the sleep EEG. Manifestations of chronic intoxication with anorectic drugs include severe dermatoses, marked insomnia, irritability, hyperactivity, and personality changes. The most severe manifestation of chronic intoxications is psychosis, often clinically indistinguishable from schizophrenia. *Use in Pregnancy*: Although rat and human reproductive studies have not indicated adverse effects, the use of Tenuate by women who are pregnant or may become pregnant requires that the potential benefits be weighed against the potential risks. *Use in Children*: Tenuate is not recommended for use in children under 12 years of age.
PRECAUTIONS: Caution is to be exercised in prescribing Tenuate for patients with hypertension or with symptomatic cardiovascular disease, including arrhythmias. Tenuate should not be administered to patients with severe hypertension. Insulin requirements in diabetes mellitus may be altered in association with the use of Tenuate and the concomitant dietary regimen. Tenuate may decrease the hypotensive effect of guanethidine. The least amount feasible should be prescribed or dispensed at one time in order to minimize the possibility of overdosage. Reports suggest that Tenuate may increase convulsions in some epileptics. Therefore, epileptics receiving Tenuate should be carefully monitored. Titration of dose or discontinuance of Tenuate may be necessary.
ADVERSE REACTIONS: *Cardiovascular*: Palpitation, tachycardia, elevation of blood pressure, precordial pain, arrhythmia. One published report described T-wave changes in the ECG of a healthy young male after ingestion of diethylpropion hydrochloride. *Central Nervous System*: Overstimulation, nervousness, restlessness, dizziness, jitteriness, insomnia, anxiety, euphoria, depression, dysphoria, tremor, dyskinesia, mydriasis, drowsiness, malaise, headache; rarely psychotic episodes at recommended doses. In a few epileptics an increase in convulsive episodes has been reported. *Gastrointestinal*: Dryness of the mouth, unpleasant taste, nausea, vomiting, abdominal discomfort, diarrhea, constipation, other gastrointestinal disturbances. *Allergic*: Urticaria, rash, ecchymosis, erythema. *Endocrine*: Impotence, changes in libido, gynecomastia, menstrual upset. *Hematopoietic System*: Bone marrow depression, agranulocytosis, leukopenia. *Miscellaneous*: A variety of miscellaneous adverse reactions has been reported by physicians. These include complaints such as dyspnea, hair loss, muscle pain, dysuria, increased sweating, and polyuria.
DOSAGE AND ADMINISTRATION: Tenuate (diethylpropion hydrochloride): One 25 mg. tablet three times daily, one hour before meals, and in midevening if desired to overcome night hunger. Tenuate Dospan (diethylpropion hydrochloride) controlled-release: One 75 mg. tablet daily, swallowed whole, in midmorning. Tenuate is not recommended for use in children under 12 years of age.
OVERDOSAGE: Manifestations of acute overdosage include restlessness, tremor, hyperreflexia, rapid respiration, confusion, assaultiveness, hallucinations, panic states. Fatigue and depression usually follow the central stimulation. Cardiovascular effects include arrhythmias, hypertension or hypotension and circulatory collapse. Gastrointestinal symptoms include nausea, vomiting, diarrhea, and abdominal cramps. Overdose of pharmacologically similar compounds has resulted in fatal poisoning, usually terminating in convulsions and coma. Management of acute Tenuate intoxication is largely symptomatic and includes lavage and sedation with a barbiturate. Experience with hemodialysis or peritoneal dialysis is inadequate to permit recommendation in this regard. Intravenous phentolamine (Regitine®) has been suggested on pharmacologic grounds for possible acute, severe hypertension, if this complicates Tenuate overdosage.

Product Information as of April, 1976

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References: 1. Citations available on request—Medical Research Department, MERRELL RESEARCH CENTER, MERRELL-NATIONAL LABORATORIES, Cincinnati, Ohio 45215. 2. Hoekenga, M.T., O'Dillon, R.H., and Leyland, H.M.: A Comprehensive Review of Diethylpropion Hydrochloride. International Symposium on Central Mechanisms of Anorectic Drugs, Florence, Italy, Jan. 20-21, 1977.

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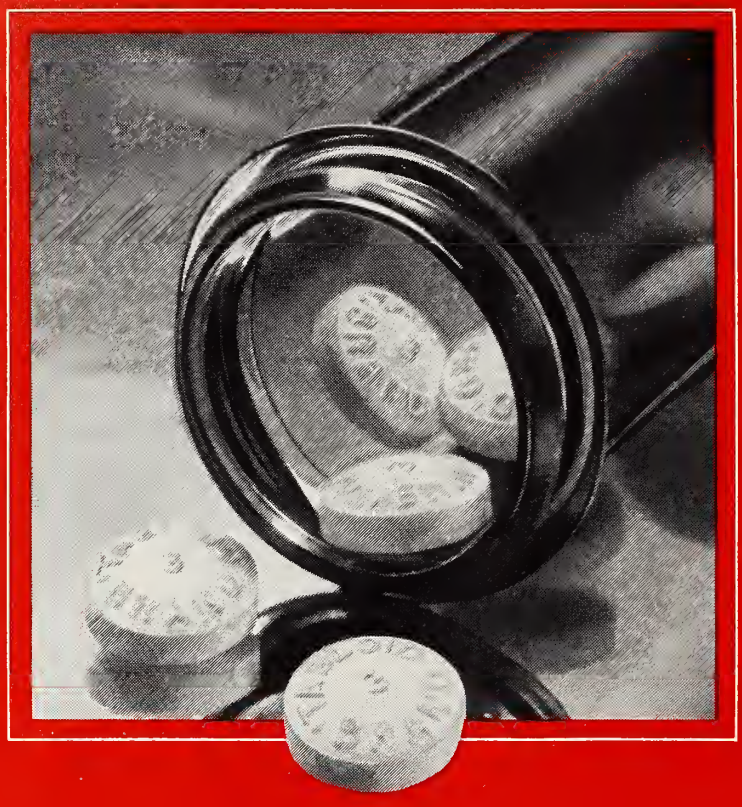
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Local Chemotherapy of Skin

MARSHALL COHEN, M.D., *Atlanta**

CHEMOTHERAPY IS A VALID and accepted treatment for removing certain superficial and low-grade skin malignancies.

The use of chemotherapy for removing skin tumors is not new; drugs such as colchicine and podophyllin have been used for many years. The latter, of course, is still the preferred method of treatment for genital warts (condyloma accuminata). Most drugs which have been used systemically are also of some benefit for topical chemotherapy. Some of those which have been used in the past include methotrexate, nitrogen mustard, and thiotepa. Generally speaking, these chemicals are not very effective in the treatment of cutaneous malignancies, and their present use is confined to experimentation. One exception is nitrogen mustard, which is quite useful for external use in mycosis fungoides and certain other lymphomas. The latest group of drugs that is proving to be effective is the retinoids.

The most commonly used chemotherapeutic drug for the treatment of skin lesions is 5-Fluorouracil (5-FU). The earliest report on the use of 5-FU on epidermal malignancies was by Klein in 1962.[1] The following year, the classic study by Dillaha et al.[2] reported on the selective cytotoxic effect of 5-FU on abnormally dividing epidermal cells. Since that time, thousands of patients have been treated successfully with minimal adverse side effects.

The most common adverse reaction to the drug is erythema and scaling. Some authors have speculated that the degree of effectiveness of 5-FU is directly proportional to its erythema. Recently, however, it has been shown that actinic keratoses may be eliminated without significant inflammation by combining 5-FU with topical triamcinolone.[3] The amount of erythema can also be minimized if the patient judiciously avoids sunlight exposure while under treatment. I routinely advise patients to use an effective PABA sunscreen while taking the drug and usually for 2 weeks thereafter. This advice should also be followed in the winter, as some ultraviolet absorption is noted by exposure to fluorescent lights and through plate glass. A 2% solution seems to be as effective as 5% for keratoses, and 10-14 days of therapy for the face is usually sufficient. Longer periods of treatment are necessary for the hands and arms.

The primary responsive lesions to 5-FU are solar (actinic) keratoses, superficial squamous cell carcinomas, superficial basal cell carcinomas, and leukoplakia. Other skin malignancies which may respond include Bowen's disease and Erythroplasia of Queyrat. These may require a higher concentration of 5-FU (usually an ointment), longer duration of treatment (up to 4 months), and possibly polyethylene occlusion. Of course, if occlusion is used, one must monitor for systemic toxicity (e.g., bone marrow depression), as absorption is greatly increased. If toxicity occurs, the treatment should be stopped.

* Dr. Cohen practices dermatology. His address is 490 Peachtree St., NE, Atlanta, GA 30308. Prepared at the request of the Georgia Division, American Cancer Society. Others wishing to contribute papers to this page are invited to send them to David B. Roberts, M.D., 2400 13th St., Columbus, GA 31906.

Some advantages of 5-FU therapy include minimal permanent scarring, early eradication of sub-clinical lesions which has an apparent long-term effect of fewer recurrences, the ability to treat multiple lesions, and its relative ease of application. If 5-FU is used for leukoplakia of the vulva, lips, hard palate or gingiva (with covering by an adhesive dressing such as orahesive), radical surgical procedures can frequently be avoided.

The mechanism of action for topical 5-FU is postulated as a blockage of DNA synthesis by inhibiting thymidylate synthetase activity. For this reason, 5-FU has been sometimes used successfully in treatment of non-malignant tumors, such as verrucae planae and distal intraurethral warts.

Recently, several cases have been reported of allergic contact dermatitis both to 5-FU and its vehicle of propylene glycol.[4] Apparently, the end result of pre- or early malignant growths is not affected by this complication; indeed, it may even be enhanced by adding an immunologic element. This condition can be treated, of course, with topical steroids. The use of fluorinated steroids on the face is not contraindicated with 5-FU, since the medicament should not be needed for over a month.

In summary, 5-FU chemotherapy has been proven successful in the treatment of thousands of patients with pre-malignant keratoses and is a valid alternative for selected persons with superficial basal and/or squamous cell carcinomas. The safety of the drug, if used with certain outlined precautions, is unquestioned. Its effectiveness and ultimate cosmetic results are also superior. Other chemicals may in the future prove to be effective for the treatment of skin lesions, but now 5-FU is, practically speaking, the only chemotherapeutic drug recommended for routine use in treatment of cutaneous malignancies.

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2. Dillaha CJ, Jansen GT, Honeycutt WM, Bradford AC: Selective cytotoxic effect of topical 5-Fluorouracil. Arch Dermatol 88:247-256, September 1963.
3. Breza T, Taylor JR, Eaglstein WH: Noninflammatory destruction of actinic keratoses by Fluorouracil. Arch Dermatol 112:1256-1258, September 1976.
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Revised Death Certificate to Be Implemented January 1, 1979

The Georgia Department of Human Resources (DHR), Vital Records Service, is introducing a revised death certificate as of January 1, 1979. This certificate replaces all previous DHR death certificates.

The revised certificate is a two-part form. The state copy is for permanent filing at the state office, and the local copy is for county Vital Records custodian files. Because of the carbon interleaving, the certificate must *not* be folded when mailed. All funeral directors who mail certificates to physicians will have access to large envelopes which are available at all county Vital Records registrar's offices.

The certificate is based on the national standard death certificate. The revised format is being used in most other states in the nation. This format will provide better data compatibility and statistical comparability at the national and state level.

Please note that a definite problem exists throughout the state concerning the legibility of information entered on death certificates. Physicians are urged, requested, implored to *print* the information regarding cause of death. In addition, physicians are urged (etc.) to return signed certificates within 48 hours of the person's death, unless otherwise specified by law, in order that the DHR can process these certificates expeditiously.

A Death Registration Manual has been prepared for distribution to all persons concerned with completion of death certificates in Georgia. The manual may be obtained free of charge from the Vital Records Service, Room 217-H, 47 Trinity Avenue, S.W., Atlanta, GA 30334. All questions should be directed to Michael R. Lavoie, Director, Vital Records Service, at the same address or phone (404)-656-4901.

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PERSONALS

First District

Curtis Hames, M.D., of Claxton, is studying selenium, a trace element, as a possible key to the high death rate in the Evans County area. In an address to the quarterly meeting of the Chatham County Unit of the Georgia Heart Association, Dr. Hames stated that for at least the past 23 years the tri-state plains area has had some of the highest death rates per 100,000 (relating to heart disease) and blacks have approximately twice as much hypertension as do whites. His theory is that the population in this area may not get the proper amount of selenium in their food or drinking water.

Second District

Terrell Davis, M.D., from Tifton, spoke to the November meeting of Waycross Chapter Full Gospel Business Men's Fellowship International (FGBMFI). The Waycross Chapter is part of a world-wide organization whereby business men and women testify to the workings of God in their lives. Dr. Davis says he accepted Christ into his heart at the age of 12 and was baptized in the Holy Spirit in 1973.

E. E. Flournoy, Jr., M.D., Albany, has been elected a delegate in the Georgia Academy of Family Physicians and will serve as the state's representative to the American Academy of Family Physicians. He was installed during ceremonies at the academy's annual meeting in Atlanta.

Third District

Robert B. Martin, III, M.D., physician and surgeon in Randolph for 32 years was honored in October by the Patterson Hospital Auxiliary in Cuthbert, Georgia. More than 500 persons attended the festivities to honor Dr. Martin. Martin, 63, came to Cuthbert in 1939, and entered the Army a year later and served in the South Pacific and Japan until 1946. He is a Fellow in the College of Surgeons, a Seaboard Railway doctor and chief of surgery at the local hospital. He has been a city council member for 31 years and is active in Rotary Club and the First Baptist Church.

V. C. Wade, M.D., formerly of Valdosta, has returned after several years of practice in Americus. He has opened his practice in the Doctor's Building.

Fifth District

At the 72nd Annual Scientific Assembly sponsored by the Southern Medical Association (SMA) and the Medical Association of Georgia, **E. Napier Burson, Jr., M.D.,** was named Second Vice-President for 1978-79 of the SMA. Also at that Assembly, **Edwin C. Evans, M.D.** of Atlanta was elected Chairman of the Council for the 1978-79 SMA.

The American College of Chest Physicians (ACCP) recently conferred Fellowship to 160 physicians and surgeons in formal ceremonies held during the ACCP's 44th Annual Scientific Assembly in Washington, D.C. **Maury C. Newton, Jr., M.D.,** from Marietta and **Raymond A. Young, M.D.,** from Rome were among those honored.

The ophthalmology group in the Piedmont Professional Building Annex has had a very busy October and November, 1978. At the American Academy of Ophthalmology in Kansas City in October, courses were taught on "Intraocular Melanoma and Retinal Detachment Complications" by **William Hagler, M.D.** and **William Jarrett, M.D.** Courses were also taught on the

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"Surgical Correction of Patients Wearing Artificial Eyes and Blepharoplasty Techniques" by **Clinton McCord, M.D.**, and a paper was presented by **Thomas Harbin, M.D.**, on "Intraocular Pressure Changes Following Cryopexy."

At the Southern Medical Meeting in Atlanta in November the following papers were presented: "The ELIZA Test and Toxocara canis," by **Zane Pollard, M.D.**; "Orbital Decompression," by **Clinton McCord, M.D.**; "Management of Intraocular Foreign Bodies," by **William Hagler, M.D.** and **William Jarrett, M.D.**; "Cysts of the Anterior Chamber," by **Alvin North, M.D.**; and "Laser Iridotomy," by **Thomas Harbin, M.D.**

Mrs. Robert (Nony) McMichael, state president of the Women's Auxiliary to the Medical Association of Georgia spoke at a meeting of a local Medical Auxiliary in November.

Seventh District

Ben Anderson, M.D., of Cedartown, has been named Vice Speaker of the Georgia Academy of Family Physicians. Dr. Anderson was installed in November ceremonies in Atlanta. As vice speaker, he will assist in the administration of the Congress of Delegates, the Academy's governing body.

Gil Maddox, M.D., an anesthesiologist, **James Pope, M.D.,** a peripheral vascular surgeon, and **Paul Gentry, M.D.,** and **Phil McGhee, M.D.,** both family practitioners, have set up practice in Carrollton in recent months. They all graduated from Carrollton High School and West Georgia College and are coming home again after additional training in far away places.

Eighth District

Robert A. Pumpelly, Jr., M.D., and **Ollie O. McGahee, Jr., M.D.** were elected to offices in the Georgia Academy of Family Physicians, the organization which represented Georgia's more than 600 family doctors. Dr. Pumpelly was named president-elect. He will assume the office of president in November 1979. Dr. McGahee is the Academy's alternate delegate to the American Academy of Family Physicians.

Ninth District

John R. Bladowski, M.D., has joined the Toccoa Clinic Medical Associates. He is a Diplomate of the American Board of Otolaryngology with limitation of his practice to ear, nose and throat, related allergy, and facial plastic surgery. Before coming to Toccoa Dr. Bladowski was in private practice in Miami, Florida, where he was consultant for the Homestead Air Force Base Hospital and clinical professor of otolaryngology at the University of Miami School of Medicine. He is married and has three children. They attend a Methodist church.

James French, M.D., a Gainesville gynecologist, has relocated his practice to the newly-completed Lanier Medical Park.

Jasper physician, **G. H. Perrow, M.D.,** has been named vice-president of the Georgia Academy of Family Physicians. Dr. Perrow was installed in the office during Nov. 3 ceremonies in Atlanta. Dr. Perrow will serve with the Academy's new president, **Milton I. Johnson, Jr., M.D.,** of Macon, for the 1978-79 term.

Tenth District

Louisville physician, **Walter Revell, M.D.,** was installed in November as the Tenth District Director of the Georgia Academy of Family Physicians. The tenth district includes Academy members who practice in east central Georgia. Dr. Revell was installed in the office during November ceremonies in Atlanta, part of the Academy's annual meeting.

The Second Annual Charles T. Cowart Award for Excellence was presented to **Miss Sue Yates** as the most outstanding member of the graduating class of the School of X-Ray Technology, West Georgia Medical Center.

Patton Smith, M.D., a family practitioner, appeared on the NBC Today Show on November 24. As Medical Director of the Monroe County jail and a member of MAG's Committee on Prison Health Care, Dr. Smith spoke on the "AMA Program to Improve Health Care in Jails." The focus was on the Monroe County jail in Forsyth, Georgia, which has been participating in the MAG Pilot Project since 1976 and which received accreditation for its medical program in June 1978.

SOCIETIES

The Auxiliary to the Muscogee County Medical Society donated cardio-pulmonary resuscitation (CPR) manikins to the Society to be used for CPR training. The society coordinated CPR training for all local physicians through the three local hospitals. The gift of the auxiliary, worth approximately $2,500, consists of a Recorder-Anne, two Resusci-Annes, a Resusci-Baby and a film entitled "Pulse of Live."



(L-R): Bruce C. Newsom, M.D., President, Muscogee County Medical Society (MCMS), Mrs. William C. Flanagan, President, Auxiliary to the MCMS, and Mrs. James M. Eaton, Immediate Past President of the Auxiliary to MCMS.

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DEATHS

Joseph Yampolsky

Joseph Yampolsky, M.D., 86, chief emeritus of the Department of Pediatrics at Georgia Baptist Hospital, died on October 29, 1978.

Known as "Dr. Yam" by his patients, Dr. Yampolsky served his internship at Lincoln Hospital and Willard Parker Hospital for Contagious Diseases. He came to Atlanta in 1920 and was appointed to the Department of Pediatrics at Emory University School of Medicine.

During his 50 years of active practice, Dr. Yampolsky pioneered research of congenital syphilis in children. He was the first to describe the treatment of syphilis of the newborn by an intraperitoneal method, the first to describe syphilitic aortitis in children under the age of 10, and the first to prove that spinal meningitis could be treated without the use of Alexander's anti-influenza serum.

Dr. Yampolsky was a diplomate of the American Board of Pediatrics, a fellow of the American Academy of Pediatrics, and a Fellow of the American College of Physicians. He was the first editor of the Fulton County Medical Society Bulletin, from 1929 to 1936.

Dr. Yampolsky was the only person ever to twice receive the Fischer Prize award for original work by the Fulton County Medical Society. He served twice as president of the Georgia Chapter of the American Academy of Pediatrics.

Survivors include his wife, a daughter, and a sister.

David James Hughes

David James Hughes, 54, a professor of medicine at Emory University School of Medicine, died on November 5, 1978. A native of Charleston, SC, Dr. Hughes graduated from The Citadel and Emory University School of Medicine, where he was a member of Alpha Tau Omega society fraternity and Phi Chi medical fraternity. He was former president of the Emory Alumni Association and a member of the Medical Association of Atlanta and the American Medical Association.

Survivors include his wife, 2 daughters, a son, his mother, and a brother.

Shelton Palmer Sanford

Shelton Palmer Sanford, M.D., 82, former head of the U.S. Public Health Service Hospital in Savannah, died on October 23, 1978, at Athens General Hospital.

A native of Marietta and a graduate of the University of Georgia, he served in World War I. He graduated from Harvard Medical School and served in the U.S. Navy. He was head of the then Marine Hospital in Savannah from 1931 until 1942, when he was assigned to foreign service for World War II.

Surviving are his wife, a daughter, and a nephew.



When the power of imparting joy
Is equal to the will, the human soul
Requires no other Heaven.

P. B. Shelley: Queen Mab, II, *1813*

I've told this before . . .

(Editor's note: Heaven only knows what you'll find when you get to church! See why in the following anecdote. Others wishing to contribute to this page should send their stories to the attention of the Managing Editor of the Journal.)

Possum in the Church

MY FATHER told me this story when I was a little boy. He said he had heard it from his father and that it was a true one. Since then, I have heard many variations of it, and in case you have not, here it is:

My grandfather owned a few hundred acres of land out near Conyers. It was a modest farm, not a plantation. Either on their land or adjacent to it lived a black man with his wife and six children. My grandfather and his brothers used to play with these children when the chores of the farm were not too demanding.

In the fall 1 year, the black children found a half-grown possum up a small persimmon tree. They shook the tree vigorously, and the little possum fell out. They were afraid of each other at first: the possum hissed and bared his teeth, and the children kept their distance. The children's gentle and persistent coaxing, not to mention the offer of a ripe persimmon, calmed the little animal's fears, and he became friendly in return. After a while, the question came up about what they were going to do with their pet. The oldest said, "If us takes him home, Pa will eat him. You know's how he loves possum." Another suggested, "Let's put him in the chicken coop out behind the barn." They wondered how they were going to feed him and keep him hidden; and they couldn't make up their minds about what to do. They had all sorts of ideas, but they finally ran out of time, as it was getting dark. So one of them said, "Let's just put him in the church (which was nearby) for tonight. We'll get him tomorrow, and maybe by then we'll know what to do with him." So they took the little possum to the AME Methodist Church, checked the doors and windows to make sure they were closed, put a handful of persimmons behind one of the pews, closed the front door, and ran home as fast as they could.

The next day was Saturday, and it was time to gather the sweet potatoes. This involved plowing up an acre or two of potatoes, collecting them, gathering pine straw, then hauling all of this to the house, and hilling them for winter consumption. This was a family project and took all day. In hushed whispers, the little boys worried about the little possum off and on all day, "All by hisself, wid no water, in the AME Methodist Church!"

The next day was the third Sunday in October, and the faithful gathered from miles around at the church to hear the Reverend Ezekiel Jackson extoll the virtues of the good with great rewards and condemn the sinners to a very hot place indeed.

And so the father announced to the family assembled at breakfast that the children should sweep the yard, while their mother heated plenty of hot water. They were all to bathe, put on clean clothes, eat dinner, and arrive at church in time for the 2 o'clock service.

The little boys looked at each other, with a helpless look in their wide eyes. But there was nothing they could do, because "Pa had done spoke!"

Those faithful who had already gathered together were singing the first hymn when the family arrived. The preacher had on a fork-tailed coat and was sitting in a big chair a little to the side of the podium. He had on his gold-rimmed spectacles, had crossed his legs, and was intently reading his Bible. Of course, the first thing the little boys did was look for their friend. Just about the time that they decided he had escaped, they spied him on a rafter, just above the pulpit. He was lying there

real still, with his tail draped over his body, and his head stretched out along the rafter. All they did was watch the little possum, and it looked like the possum was watching the preacher.

The Reverend Jackson was well along in his sermon and had warmed to his subject. He gave illustrations of sin and sinners and illustrations of the pure in heart. He pointed his finger at the flock, in different directions, and said in a loud voice, "And where do sinners go? There!" and he pointed straight down and added, "into the fires of Hell, to the Devil, to the Devil, to the Devil!"

"And where do the pure in heart, the lambs and the sheep go?" He pointed overhead at the rafter where the little possum was. "To God," he said, "To God." Then he looked up piously and said again, "God Damn! What a rat!!!"

J. G. McDaniel, M.D.
820 W. Wesley Rd. NW
Atlanta, GA 30327

Teach him to live rather than to avoid death: life is not breath, but action, the use of our senses, our mind, our faculties, every part of ourselves which makes us conscious of our being.

Jean Jacques Rousseau [1712-1778]: Émile, *Bk. I (tr. by Barbara Foxley).*

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938 Peachtree Street, NE / Atlanta, Georgia 30309

MANUSCRIPTS—Articles are accepted for publication on the condition that they are contributed solely in this **Journal.** Manuscripts should be typewritten, double-spaced, and the **original and one copy should be submitted.** Receipt of manuscripts will be acknowledged and unused manuscripts returned. Used manuscripts will be returned only if requested.

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THE COVER

The Georgia Heart Association is featured in this month's issue, and our pride in their accomplishments is reflected in the bold cover design by Richard Lyons of TSC Marketing Services.

Letters to the Editor . . .

December '78 Issue Praised

Dear Sir:

I was delighted with the holiday editorial of the December issue of the *Journal of the Medical Association of Georgia*. The article by Dr. James Mallory promoting a return to the simplicity of the Gospel in our Christmas celebration was refreshing to read not only as a reflection of his Christian commitment but also of the background of Christianity that I am sure characterizes the leaders of the Association. Thank you for printing this article, we need many more reminders like this.

Richard A. Hansen, M.D.
Wildwood

Dear Sir:

Just a note to thank you for the December 1978 issue of the *Journal of the Medical Association of Georgia* featuring the Medical College of Georgia on the occasion of its 150th birthday celebration. The cover illustration was most attractive and conveyed the pride we have in our past as well as our plans and hope for the future.

May 1979 bring you continued health and happiness.

Lois T. Ellison, M.D.
Augusta

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MEDICAL MEETING CALENDAR

MARCH

3-10 — *Snowmass, CO;* **FOURTH ANNUAL SNOW JOB IN GYNECOLOGY AND OBSTETRICS;** Category 1 credit; Contact: Associate Dean for CME, 69 Butler St., S.E., Atlanta 30303. PH: 404/588-3534.

5-8 — *Atlanta;* **18TH NATIONAL CONFERENCE ON THE DETECTION AND TREATMENT OF BREAST CANCER;** Category 1 credit; Contact: American College of Radiology, 6900 Wisconsin Ave., Chevy Chase, MD 20015. PH: 301/654-6900.

6-9 — *Tamarron Ski Resort, CO;* **EMERGENCY MEDICINE;** Category 1 credit; Contact: Division of Continuing Education, Medical College of Georgia, Augusta 30901. PH: 404/828-3967.

8-9 — *Winston-Salem, NC;* **TWO-DAY REAL TIME COURSES FOR OBSTETRICIANS;** Category 1 credit; Contact: James F. Martin, M.D., Director, Center for Medical Ultrasound, Bowman Gray School of Medicine, Winston-Salem, NC 27103.

8-10 — *Atlanta;* **TRANSCUTANEOUS ELECTRICAL NERVE STIMULATION: PRINCIPLES AND APPLICATIONS FOR THE CLINICIAN;** Category 1 credit; Contact: Steven L. Wolf, Ph.D., Center for Rehabilitation Medicine, 1441 Clifton Rd., N.E., Atlanta 30322.

9-10 — *Winston-Salem, NC;* **FRANK R. LOCK SYMPOSIUM IN OBSTETRICS AND GYNECOLOGY;** Contact: Emery C. Miller, M.D., Associate Dean for CME, Bowman Gray School of Medicine, Winston-Salem, NC 27103.

11-14 — *Atlanta;* **ATLANTA GRADUATE MEDICAL ASSEMBLY;** Category 1 credit; Contact: Winnie Hopkins, 875 W. Peachtree St., N.E., Atlanta 30309. PH: 404/881-6128.

15-16 — *Augusta;* **REPRODUCTIVE ENDOCRINOLOGY;** Contact: Division of Continuing Education, Medical College of Georgia, Augusta 30901. PH: 404/828-3967.

15-17 — *Atlanta;* **ANNUAL SYMPOSIUM ON SURGERY OF THE HAND: UPDATE IN CURRENT CONCEPTS OF HAND MANAGEMENT;** Category 1 credit; Contact: Associate Dean for CME, 69 Butler St., S.E., Atlanta 30303. PH: 404/588-3534.

18-21 — *Bal Harbour, FL;* **SOUTHEASTERN SURGICAL CONGRESS 47TH ANNUAL ASSEMBLY;** Category 1 credit; Contact: A. H. Letton, M.D., 315 Boulevard, N.E., Atlanta 30312.

21-22 — *Atlanta;* **STARTING YOUR PRACTICE (WORKSHOP FOR RESIDENTS);** Category 1 credit; Contact: Sue McAvoy, MAG, 938 Peachtree St., N.E., Atlanta 30309. PH: 404/876-7535.

22-24 — *Pensacola Beach, FL;* **SECOND ANNUAL PATIENT EDUCATION CONFERENCE;** Category 1 credit; Contact: Shirley Garnett, Learning Resource Center, West Florida Hospital, 8383 N. Davis Hwy., Pensacola, FL 32504. PH: 904/478-4460, ext. 692.

22-24 — *Kissimmee, FL;* **10TH ANNUAL TOPICS IN INTERNAL MEDICINE:** Category 1 credit; Contact: Bill Rockwood, University of Florida College of Medicine, Box J-233, JHM Health Center, Gainesville, FL 32610. PH: 904/392-3143.

22-24 — *Orlando, FL;* **INTERNATIONAL CONFERENCE ON TUBERCULOSIS;** Category 1 credit; Contact: Dale E. Braddy, Director of Education, American College of Chest Physicians, 911 Busse Hwy., Park Ridge, IL 60068.

23-25 — *Atlanta;* **FOURTH ANNUAL DOGWOOD CONFERENCE;** Contact: Ronald Peyton, Scottish Rite Hospital, 1001 Johnson Ferry Rd., N.E., Atlanta 30342. PH: 404/256-5252.

25-28 — *Atlanta;* **FIFTH ANNUAL MEETING OF THE AMERICAN SPINAL INJURY ASSOCIATION;** Contact: David Apple Jr., M.D., 3280 Howell Mill Rd., N.W., Atlanta 30327. PH: 404/352-2234.

26-28 — *Savannah;* **SELECTED TOPICS IN OPHTHALMOLOGY;** Contact: Division of Continuing Education, Medical College of Georgia, Augusta 30901. PH: 404/828-3967.

26-April 6 — *Atlanta;* **LAB METHODS IN DERMATOLOGIC MYCOLOGY;** Contact: Center for Disease Control, Bureau of Lab, Public Health Service, 1600 Clifton Rd., Atlanta 30333.

29-30 — *Chattanooga, TN;* **PEDIATRICS;** Contact: Dennis K. Wentz, M.D., University of Tennessee Center for Health Sciences, 62 S. Dunlap St., Memphis, TN 38163. PH: 901/528-5605.

29-30 — *Atlanta;* **THE TREATMENT OF ARTHRITIS — UPDATE;** Category 1 credit; Contact: Associate Dean for CME, 69 Butler St., S.E., Atlanta 30303. PH: 404/588-3534.

29-30 — *Atlanta;* **MANAGEMENT OF FIRE SAFETY IN HOSPITALS WITH EMPHASIS ON NEEDS OF THE HANDICAPPED;** Contact: Department of Rehabilitation Medicine, 1441 Clifton Rd., N.E., Atlanta 30322. PH: 404/329-5507.

29-31 — *Hilton Head, SC;* **PSYCHOPHARMACOLOGY FOR THE PRIMARY PHYSICIAN;** Category 1 credit; Contact: Joe E. Freed, M.D., William S. Hall Psychiatric Institute, P.O. Box 119, Columbia, SC 29202.

APRIL

2-4 — *Atlanta;* **INFECTIOUS DISEASE AND IMMUNOLOGY FOR THE PEDIATRICIAN;** Category 1 credit; Contact: Associate Dean for CME, 69 Butler St., S.E., Atlanta 30303. PH: 404/588-3534.

4-6 — *Augusta;* **CARDIOLOGY;** Contact: Division of Medical Education, Medical College of Georgia, Augusta 30901. PH: 404/828-3967.

5-6 — *Atlanta;* **DERMATOLOGY POSTGRADUATE COURSE;** Category 1 credit; Contact: Associate Dean for CME, 69 Butler St., S.E., Atlanta 30303. PH: 404/588-3534.

6-7 — *Atlanta;* **ANNUAL MEETING OF THE SOUTHERN SOCIETY OF PHYSICAL MEDICINE AND REHABILITATION;** Contact: Robert Christopher, M.D., 800 Madison, Memphis, TN 38163. PH: 901/528-5500.

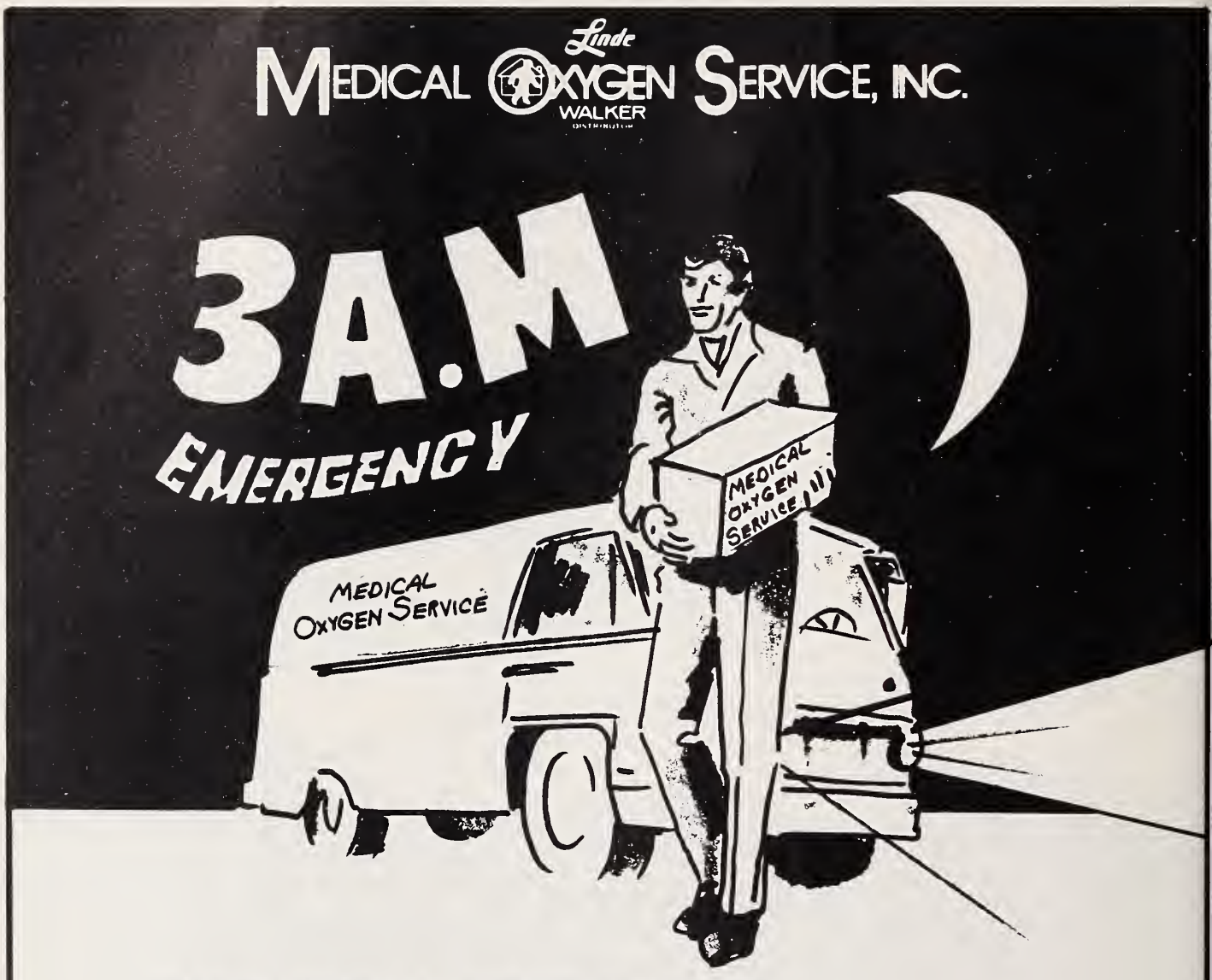
6-8 — *Atlanta;* **CORONARY DISEASE, EXERCISE TESTING, AND CARDIAC REHABILITATION;** Category 1 credit; Contact: International Medical Education Corp., 64 Inverness Dr. East, Englewood, CO 80112. PH: 800/525-8646.

11-13 — *Atlanta;* **FIFTH ANNUAL COURSE ON TECHNIQUES IN ORTHOPAEDIC SURGERY: RECONSTRUCTIVE SURGERY OF THE KNEE;** Category 1 credit; Contact: Associate Dean for CME, 69 Butler St., S.E., Atlanta 30303. PH: 404/588-3534.

12-14 — *Atlanta;* **PERSPECTIVES IN SURGERY;** Category 1 credit; Contact: Associate Dean for CME, 69 Butler St., S.E., Atlanta 30303. PH: 404/588-3534.

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The Georgia Heart Clinic System: Three Decades of Service

NANETTE K. WENGER, M.D., and MARY FORTSON JOHNSON, *Atlanta**

WHEN MANY PHYSICIANS in Georgia think of the Heart Association, they think first of the Georgia Heart Clinic System and the care it has provided to thousands of needy heart patients over the past 30 years. Established in 1949 and expanded within a few years to a network of clinics serving patients from every county in Georgia, this Clinic System was the first of its kind in the nation. It has been a successful, long-term partnership of the Heart Association, providing coordination and funding, the hospitals in which the clinics are located, the physicians who donate so many hours of their time, and the physicians who refer patients to the clinics.

What is the history of the Clinic System, and what has been its impact on the treatment of cardiovascular disease in Georgia? When the Georgia Heart Association (GHA) was founded in 1948, there were only two cardiovascular clinics in the state. One was at Grady Hospital in Atlanta (discontinued during World War II, but reactivated soon afterward). The other was at Eugene Talmadge Memorial Hospital in Augusta. The founders of GHA knew there were many people with cardiovascular disease throughout the state who could not afford to pay for the medical diagnosis and care they so desperately needed. At the same time, major advances were taking place in the management of patients with heart disease.

With this in mind, the early Heart Association leaders, Drs. Bruce Logue, the founding President, and Tom Ross and Gordon Barrow, planned a conference for January 1949. Physician members of the Heart Association were invited to discuss the problem and suggest ways to solve it. It was agreed by those attending the conference that the Heart Association, as a voluntary health organization, would never be able to provide direct patient care or to pay for the individual expenses of every patient. But physician consultations could be offered and referrals made to state agencies.

The physicians went back to their homes throughout Georgia and began to talk with other physicians to interest them in establishing clinics to provide services to needy heart patients. The clinics would accept only patients referred by a physician and certified as medically indigent by their local welfare departments. Physicians would donate their services, space would be provided locally, and the Heart Association would underwrite the cost of equipment, a nominal petty cash fund, and some secretarial assistance.

GHA itself never operated the clinics; they were operated by the community physicians. (Most clinics established in the early days were located in health centers; over the years, this has changed until now all are located in hospitals.) From the two original clinics at the medical school teaching hospitals, Grady (Emory) and Talmadge (Medical College of Georgia), two additional clinics were established in 1949, one in Savannah, and one in Albany. Another clinic opened in Athens next, and others followed in various other communities within 18 months. The

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In the earlier days of the Macon Heart Clinic, Dr. Tom Ross (L), a past president of the Georgia Heart Association, and other Clinic physicians hold consultation as an infant patient is examined.

Clinic System has grown to include 15 clinics, with more than 200 physicians giving 10,000 hours of professional time to handle 30,000 patient visits a year.

In 1954, a need was identified for a facility to handle medically indigent patients with complicated heart problems who lived outside the area served by the Grady Clinic. St. Joseph's Infirmary and the Charles G. Giddings Foundation cooperated in the formation of the Giddings Memorial Heart Clinic. Giddings soon came into the Georgia Heart Clinic System, providing a center for advanced diagnosis, treatment, and surgery where special patients from anywhere in the state could be channeled after primary diagnosis at other clinics in the system. GHA provided the Giddings Clinic with additional equipment for advanced treatment and awarded a clinical fellowship to a resident physician at the clinic each year to assure the highest level of experience and training.

Many events took place in the early years of the Clinic System. A few milestones include:

—A manual published by GHA, entitled, "An Optimum Program for Rheumatic Fever and Congenital Heart Patients in Georgia," formed the basis for the cardiac program of the Crippled Children's Division in Georgia. The Georgia Heart Clinic System did the initial case finding and patient screening before referral to the Crippled Children's Service.

—When the Heart Disease Control Program was established in the State Health Department, this program and the Clinic System coordinated their efforts to avoid duplication of services. Heart Disease Control funds were used for clinic equipment, such as electrocardiograph machines and fluoroscopes, while the GHA paid for office equipment, such as filing cabinets and tables that could not be purchased through the federally-funded Heart Disease Control Program. Physicians continued to volunteer their services.

—One matter of great concern to physicians in the clinics was that many rheumatic fever patients could not afford the long-term medication needed to prevent recurrent rheumatic fever. As a result, the Heart Disease Control Program agreed to provide rheumatic fever prophylactic medication without charge to clinic patients. Later, this service was extended to patients of any physician who certified that the patient was unable to afford needed prophylactic medication.

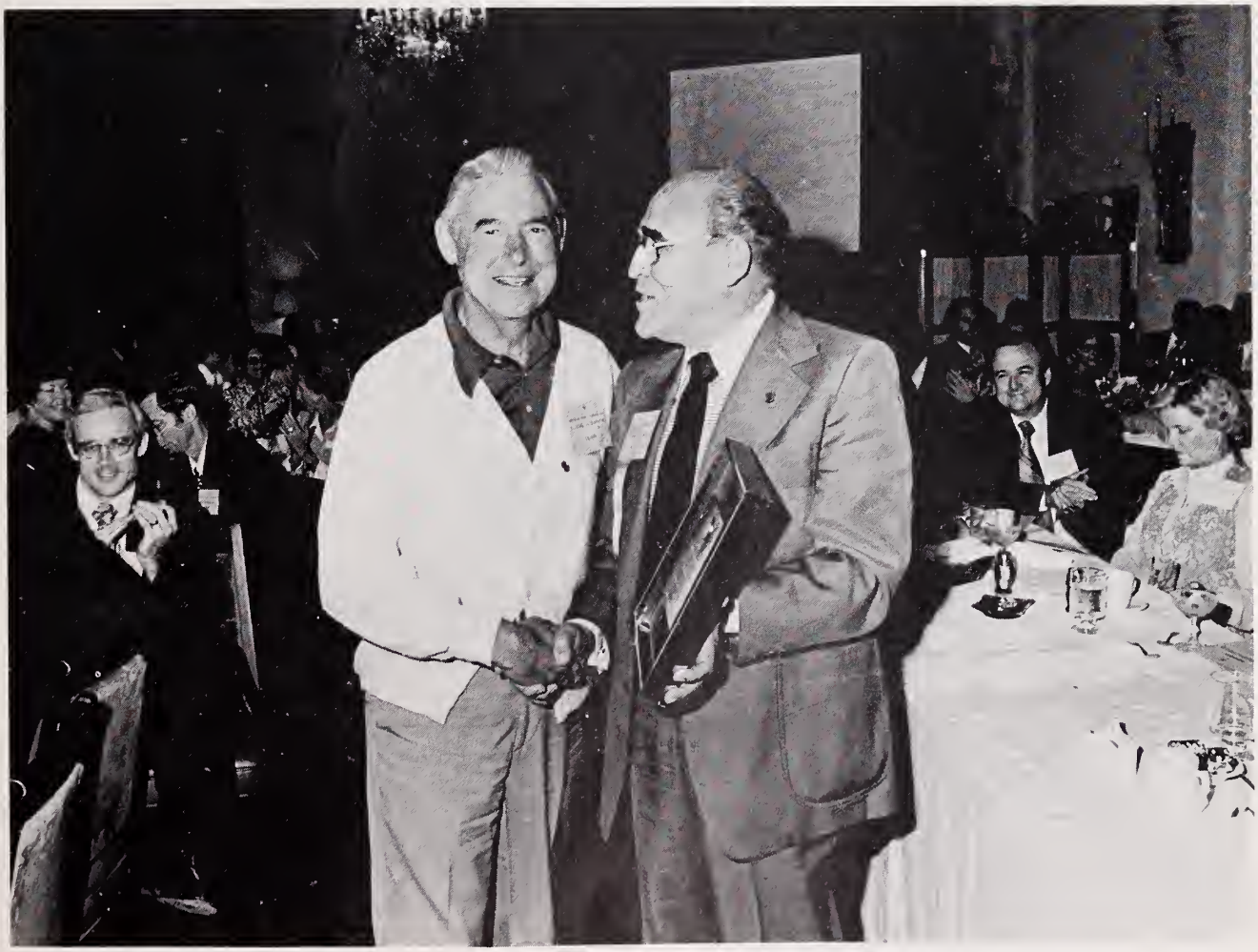
—Many of the adult patients treated in the clinics were capable of returning to work, but employers often were reluctant to rehire them. The interest of physicians in returning these men and women to

work led to cooperative efforts with the Division of Vocational Rehabilitation (DVR) of the State Department of Education. DVR helped with the appropriate vocational counseling and placement of cardiac patients, as well as with funding surgery and other restorative procedures for patients over 16 years of age who were not eligible for the services of the Crippled Children's Division.

With the growing number of organizations and facilities offering services to cardiac patients over the years, coordination became increasingly important. The GHA assumed this role by organizing clinic tours and conferences. Yearly tours of the heart clinics were conducted by members of GHA's State Clinics Committee and by physicians participating in the clinics. Every third year, in lieu of a tour, a Clinic Personnel Conference was held in a central location. All organizations and agencies offering services to cardiac patients took part in the tours and the conferences. This gave everyone involved with the clinics a regular opportunity to understand the services and policies of the cooperating agencies and to help keep the referral and reporting mechanisms functioning smoothly.

The advent of Medicaid and other third party payment systems changed somewhat the definition of indigency and reduced appreciably the number of patient visits handled by some clinics. Nevertheless, the Clinic System has continued to serve about 20,000 patient visits a year. Because of the adequacy of governmental and other funding, the GHA Board of Directors, after careful study, voted to phase out its financial support of the Clinic System effective June 30, 1979. Fortunately, all clinics with the exception of the one in Albany will continue to operate under the auspices of the hospitals where they are located.

The Clinic System has made a major contribution to cardiovascular medicine and to the care of cardiac patients in Georgia. This month GHA, as in the past, will pay tribute to the Clinic System volunteer physicians who have helped meet the needs of heart



Dr. T. Sterling Claiborne (L) of Atlanta receives a plaque from Myer O. Sigal of Macon, immediate past chairman of the board of the Georgia Heart Association (GHA), for 38 years of service to the Grady Heart Clinic in the Georgia Heart Clinic System. The presentation took place at GHA's Annual Meeting in Savannah in September 1978.



Dr. Harry Parks of Atlanta examines a patient in the Heart Clinic at Grady Memorial Hospital in Atlanta. Dr. Parks received recognition recently from the Georgia Heart Association for 39 years of service to the Georgia Heart Clinic System, more than any other physician volunteer in the statewide system.

patients in Georgia. Gold, Silver, and Bronze Meritorious Service Medallions and Clinic Certificates are being presented to 103 Georgia physicians in 12 clinics of the Georgia Heart Clinic System (see box). Two physicians being honored, Dr. Harry Parks of Atlanta with 39 years of service and Dr. Sterling Claiborne of Atlanta with 38 years, pre-date the Clinic System itself with their volunteer services to cardiac patients and are recipients of special Heart Association awards.

Both Dr. Parks and Dr. Claiborne, the latter an incorporator of GHA and its second president in 1950, speak enthusiastically of the many world-renowned and respected cardiologists, such as Dr. Eugene Stead and Dr. James Warren, who worked and taught at the Grady Heart Clinic.

Dr. Parks remembers with enthusiasm the earliest days of the Grady Cardiac Clinic when fluoroscopes were first used to help diagnose patients' heart problems and when a physician dared to suture a stab wound of the heart in the Grady emergency room one Saturday night. The patient survived! "It was valuable experience in the pioneer days of cardiology, experience a physician or a medical student couldn't get from books," Dr. Parks says. "Who would have dreamed that one day we would see patients in the clinic who had had successful heart surgery, that our clinic would someday be part of a statewide system?" Dr. Claiborne reminisced about the value of the clinic tours in updating physician information about heart disease. "A lot of great cardiologists were Clinic volunteers, and other great cardiologists were trained there," he commented, remembering the patients referred for the "new" cardiac catheterization tests and for the early surgical correction.

The Heart Clinics hold many memories for many Georgia physicians — many of whom will continue to volunteer their time in the clinics so that no heart patient in the state will be without needed care.

American Academy of Pediatrics Policy Statement Concerning Television Advertisements Directed at Children*

The quality and quantity of television advertising directed to children is a serious issue facing American parents and their children. While the average American child sees more than 20,000 commercials per year, research indicates that most children do not have the cognitive ability to adequately assess the meaning and intent of commercials. In the face of such evidence, current practices represent commercial exploitation of children for profit.

In a free society, the exercise of responsibility and restraint by advertisers and broadcasters is the ideal remedy. In the absence of such restraint, however, the American Academy of Pediatrics recommends a ban on all television advertisements during programs in which a majority of the audience is composed of children under 12 years of age as the most effective remedy.

The Academy urges pediatricians to educate themselves, their patients, and patients' parents about the issue of television advertising to children, and to remind parents that the ultimate responsibility for monitoring television's effect on children rests with the family.

* Adopted at the 48th Annual Meeting of the Academy held in Chicago.

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Georgia Heart Clinic System Awards

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Silver Meritorious Service Medallio	10-14 years
Gold Meritorious Service Medallion	≥15 years
Clinic Service Plaques	Dr. Parks — 39 years
	Dr. Claiborne — 38 years

ALBANY HEART CLINIC

Gold Meritorious Service Medallion
F. Dempsey Guillebeau, M.D.
Charles D. Hollis, Jr., M.D.
Thomas D. Johnson, M.D.
Silver Meritorious Service Medallion
Leon H. Bush, M.D.

COLUMBUS HEART CLINIC

Gold Meritorious Service Medallion
Simone Brocato, M.D.
A. J. Kravtin, M.D.
George Bertling Smith, M.D.
Bronze Meritorious Service Medallion
C. Daniel Cabaniss, M.D.
Gordon C. Miller, M.D.
Certificate
George F. Armstrong, M.D.
Robert M. Patton, M.D.

DALTON HEART CLINIC

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Royal T. Farrow, M.D.
James A. Redfearn, Jr., M.D.
Silver Meritorious Service Medallion
J. Sherwood Jones, Jr., M.D.
Bronze Meritorious Service Medallion
Carl L. Gilbert, M.D.
H. U. Martin, M.D.
Drayton M. Sanders, M.D.
William R. Tipton, M.D.
Certificate
Frank Houser, M.D.
Roddy P. Ingraham, M.D.
James S. Myers, M.D.

GAINESVILLE HEART CLINIC

Gold Meritorious Service Medallion
A. Frederick Bloodworth, M.D.
Henry S. Jennings, Jr., M.D.
Silver Meritorious Service Medallion
Robert C. Grant, M.D.
Bronze Meritorious Service Medallion
Russell E. Richardson, M.D.
Neil C. Kelley, M.D.
Samuel D. Rauch, Jr., M.D.
Certificate
James F. Parks, M.D.
Roger Owens, M.D.
W. A. Manus, M.D.
Gregory Smith, M.D.

GEORGIA BAPTIST HEART CLINIC

Silver Meritorious Service Medallion
Gerald F. Fletcher, M.D.

GEORGIA HEART CLINIC (LaGrange)

Gold Meritorious Service Medallion
William B. Fackler, Jr., M.D.
J. Render Turner, M.D.
Silver Meritorious Service Medallion
Robert B. Copeland, M.D.
Certificate
A. Lucien Cousins, M.D.

GIDDINGS HEART CLINIC (St. Joseph's Hospital)

Silver Meritorious Service Medallion
Arnoldo Fiedotin, M.D.
Bronze Meritorious Service Medallion
Stuart J. Toporoff, M.D.
Certificate
Michael A. Chorches, M.D.

GRADY HEART CLINIC

Clinic Service Plaques
Harry Parks, M.D.
T. Sterling Claiborne, M.D.
Gold Meritorious Service Medallion
J. Gordon Barrow, M.D.
J. Norman Berry, M.D.
Linton H. Bishop, Jr., M.D.
B. Woodfin Cobbs, Jr., M.D.
Nicholas E. Davies, M.D.
Edward R. Dorney, M.D.
Byron F. Harper, Jr., M.D.
Louis K. Levy, M.D.
Bernard S. Lipman, M.D.
James B. Minor, M.D.
Rosemond S. Peltz, M.D.
Sanford A. Shmerling, M.D.
Jean S. Staton, M.D.

Paul Teplis, M.D.
Charles B. Upshaw, Jr., M.D.
Nanette K. Wenger, M.D.

Silver Meritorious Service Medallion

Douglas H. Forsyth, M.D.
George W. Jones, Jr., M.D.
Thorne S. Winter, III, M.D.

Bronze Meritorious Service Medallion

Jerome B. Blumenthal, M.D.
John D. Cantwell, M.D.
Robert B. Copeland, M.D.
Thomas L. Crews, M.D.
Arnoldo Fiedotin, M.D.
Gerald F. Fletcher, M.D.
Milton Frank, III, M.D.
William C. Maloy, M.D.
Erdogan Oran, M.D.
William H. Plauth, Jr., M.D.
Fred D. Rose, M.D.
Raymond Rosenberg, M.D.
Barry D. Silverman, M.D.
Mark E. Silverman, M.D.
John H. Stone, M.D.
Stuart J. Toporoff, M.D.
Paul Walter, M.D.
Evan Weisman, M.D.

Certificate

Richard Bardack, M.D.
A. Gordon Brandau, Jr., M.D.
Robert F. Castle, M.D.
Michael A. Chorches, M.D.
Stephen D. Clements, Jr., M.D.
Kenneth J. Dooley, M.D.
Kenneth A. Hoose, Jr., M.D.
John W. Hurst, Jr., M.D.
Iverson W. Joines, II, M.D.
Stuart S. Katz, M.D.
Arthur J. Merrill, Jr., M.D.
Douglas C. Morris, M.D.
Ann C. Mortell, M.D.
Elizabeth W. Nugent, M.D.
E. Alan Paulk, Jr., M.D.
R. Beauvais Randall, Jr., M.D.
Carter Smith, Jr., M.D.
David Lewis Steinberg, M.D.
Robert L. Whipple, III, M.D.
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Davis S. Mann, M.D.
Hugh K. Sealy, M.D.

SAVANNAH HEART CLINIC

Gold Meritorious Service Medallion

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Caroline Jean Williams, M.D.
Zellner C. Young, M.D.

Bronze Meritorious Service Medallion

C. Walker Beeson, M.D.
Thomas J. Yeh, M.D.

Certificate

Loyd S. Goodman, M.D.

THOMASVILLE HEART CLINIC

Gold Meritorious Service Medallion

Huddie L. Cheney, Jr., M.D.
Clayton Courson, M.D.
Oscar M. Mims, M.D.

Bronze Meritorious Service Medallion

Marshall C. Dunaway, M.D.

UNIVERSITY HEART CLINIC

Bronze Meritorious Service Medallion

David W. Cundey, M.D.
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Morehouse College Receives Grant

The new School of Medicine at Morehouse College has received a $5,000 grant for scholarship support from the Alonzo F. and Norris B. Herndon Foundation, Inc., in Atlanta. "The Herndon Foundation award is a significant boost to our scholarship program for incoming medical students," said Dr. Hugh M. Gloster, president of Morehouse College. "[It] is another in a long-string of financial grants to historically black colleges by the Herndon Foundation."

The School of Medicine at Morehouse College opened in September 1978 as a 2-year program in the basic medical sciences. It is the first medical school to open at an historically-black college in the 20th century.

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Alexander Pope: Letter to George Walsh, 1706

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One Patient's Experience with the Georgia Heart Clinic System





Nanette K. Wenger, M.D. (Right), Professor of Medicine at Emory and director of the Cardiac Clinics at Grady Memorial Hospital in Atlanta, talks with Mrs. Nancy Clopton during a routine checkup at the Clinic.

Mrs. Nancy Clopton, 38-year-old working wife and the mother of two teenagers, has literally grown up with heart disease and with the Cardiac Clinics at Grady Memorial Hospital in Atlanta. Her medical history includes several recurrent episodes of rheumatic fever, the development of congestive heart failure in her 20's, and open-heart surgery when she was 33. "I will probably have to keep coming to the clinic for checkups for the rest of my life, but I'm fine right now, and I feel great about the future," she says.

Mrs. Clopton not only takes care of her home and family but also has a "very busy" job as a sales clerk and is on her feet 8 hours a day. She gets tired, of course. But it's not the same kind of tired she felt when she was having heart problems during most of her life.

It was fatigue, shortness of breath, and weakness that prompted Nancy's mother to bring her to the Grady Cardiac Clinic when she was only 12 years old. Physicians there found a heart murmur, traceable to rheumatic fever. Nancy has been a patient in both the Pediatric Cardiac Clinic and the Adult Cardiac Clinic at Grady. The clinics are part of the Georgia Heart Clinic System, a statewide network which was organized by the Georgia Heart Association for the diagnosis and treatment of medically indigent heart patients. The 13 clinics are located in hospitals in 10 cities, and physician volunteers donate thousands of hours for patient care each year.

In her teens, Nancy had recurring episodes of rheumatic fever which interrupted her schooling and caused her to be hospitalized at Grady and then for several months of convalescent care at Elks Aidmore Hospital in Decatur, under the auspices of the State Crippled Children's Service. Her high school years were marked by limitation of activity (no physical education classes allowed), rest after school in the afternoons, and regular checkups at the Grady Heart Clinic. Although classmates whispered that Nancy had heart problems and probably wouldn't live very long, she "had faith in God and never thought about dying."

She was married after high school and experienced no difficulties during the birth of her two children, a daughter who is now 17, and a son who is 16. When her son was only 6 months old, however, congestive heart failure developed, and she spent 11 days in the hospital at Grady. Subsequent heart catheterization revealed that both the mitral valve and the aortic valve were damaged. The faulty valves placed an excessive work load on the heart, and it was constantly enlarging. "I was told that without heart surgery I wouldn't be able to lead a useful life and that there was danger I could have a stroke from a blood clot," Mrs. Clopton said. "I prayed about it and decided to have the surgery. I wanted very much to live and be able to raise my children."

In October 1973, she had open-heart surgery at Grady Hospital to replace the mitral valve. The Division of Vocational Rehabilitation of the State Department of Education assisted with the cost of surgery. The surgery was successful, and her wish is coming true. Her children will soon be graduating

from high school, and she even talks of the day when she may be able to do some volunteer work in convalescent homes.

Mrs. Clopton is on anti-coagulant medication because of her artificial heart valve, and she visits the Cardiac Clinic every 3 or 4 months for routine checkups. At the clinic, she is counseled about preventing a recurrence of rheumatic fever, preventing infection of her heart valve, taking her medication correctly, and eating the proper food.

Otherwise, her life is normal. She even plays a little tennis in the summer. "My family has been very supportive," she said. "My mother never babied me, just treated me like any other child and didn't give in to my whims. My husband had patience and faith and offered encouragement when I needed it."

Of the clinic personnel she says, "I don't know what I'd do if I had to go to another doctor. At the clinic, they know every detail of my medical history, and I have every confidence in them. After all, I grew up with the clinic."

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Knowledge is a process of piling up facts; wisdom lies in their simplification.
Martin H. Fischer [1879-1962]: Quoted by Howard Fabing and Ray Marr in Fischerisms.

An enthusiastic report on the health care system in communist Cuba based on what the author was allowed to observe.

Delivery of Health Care Services in Cuba

BONNIE J. KAY, Ph.D., *Atlanta

In early 1978, I visited Cuba for 17 days as part of a delegation organized to facilitate people-to-people exchanges to promote international understanding. The purpose of our visit was to observe the health care delivery system on the island. I was especially interested in the nature of its evolution following the 1959 revolution that marked the communist takeover.

What It Was Like in the Past

Major medical problems in Cuba as late as the 1950's were typical of many developing Latin American countries. Such problems resulted primarily from a high prevalence of infectious diseases and malnutrition. Infant mortality rates as high as 60 per 1,000 live births were cited in 1953.[1] The mortality rate for gastroenteritis reportedly was 42.5 deaths per 100,000 population in 1957.[2] Malaria, diphtheria, and typhoid were common causes of illness and death. The accuracy of data reporting systems existing at the time has been questioned, so it is quite likely that health status statistics were underreported.[2]

Ready access to modern medical services did not exist for most Cubans. The overwhelming majority of physicians were located in a few cities, typically Havana, Santiago, in the eastern part of the island, and Camaguey, in the central part. Compounding this poor distribution of physicians was the fact that approximately half of Cuba's 6,000 doctors emigrated shortly after the Batista regime was ousted in 1959. Until then, hospital care was located principally in Havana and was too expensive for most of the population. A few first aid stations and maternal and child health centers were available to the poor,[3] but most people in the rural areas visited the *curanderos* or traditional practitioners.

A View of the Present Situation

Two and one-half weeks is hardly enough time to gather adequate information of over 9 million people, and I am constantly reminded of how selectively one "sees" as an individual, bringing a personal set of criteria and predispositions to a new experience. As part of an organized group, what I "saw" was controlled to a certain extent. We were allowed to leave the group, however, and this I did often. On numerous such walking excursions it was possible to see neighborhoods, clinics, and hospitals in Havana, as well as small rural towns unencumbered by tour buses and guides. Twelve of the 17 days were spent traveling from one end of the island to the other, with 1- or 2-day stays in Cienfuegos, Camaguey, and Santiago de Cuba. The remaining time was spent in Havana. I was impressed by the cleanliness of both big city and small town neighborhoods. Sidewalks and gutters were swept clean of refuse.

The focal point of health care delivery on the island is the polyclinic. The polyclinic was an observable part of each small town we passed through.

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Each serves a target population of approximately 25,000 persons, and is staffed by a full-time administrator, internists, pediatricians, obstetrician-gynecologists, and dentists, along with a supportive staff of nurses, dental assistants, laboratory technicians, and sanitarians. Services provided include not only curative treatment but environmental health (sanitation), community services (innoculation and screening), and social services.

The Cuban physician is specifically trained to deal with this broad range of health-related services. Part of his/her medical education includes 2 years of practice in a rural polyclinic after graduating from medical school. We spoke with several medical students from the University of Havana, and they were enthusiastic about developments in health care organization in their country.

One polyclinic in Santiago de Cuba, on the eastern tip of the island, seemed typical. Located in a busy section of the city, this clinic devoted a large part of its services to pediatrics, nutrition counseling, obstetrics-gynecology, and family planning. The two physicians on duty that day were both women. One was a pediatrician, the other was an obstetrician-gynecologist; they had practiced for 8 and 24 years, respectively. The pediatrician worked with two teams of pediatric and public health nurses. Each team was responsible for 4,000 children (infants to 14 years). The clinic had a case load of 8,000 children living in the surrounding area. Infants were usually seen once a month, more frequently if necessary. Home visits were made by the nursing teams to those patients needing special care. The obstetrician-gynecologist oversaw the clinic's family planning program in addition to providing obstetrical care. She was conducting a long-term study of patients taking oral contraceptives and was very interested to hear of the latest research published in the United States on this topic. When asked how much contraceptive use was stressed in Cuba, she replied that generally, after a woman had three children, she was counseled about using the Pill or having an intrauterine device inserted. Vasectomies are uncommon. Abortions are available, but none of these alternatives to birth control were encouraged.

From the polyclinic, the patient is referred, if necessary, to inpatient services available on a regional basis. Regional hospitals serve an area population of 250,000 and typically are 200-bed facilities offering general, secondary-care in-patient services. Since 1959, there has been a redistribution of hospitals from urban to rural areas. While rural areas have experienced at least a 50% increase in net bed population, Havana has shown a net decrease.[3]

In Holquin, located in the east-central part of the island in the heart of sugar-cane country, a new general hospital, Lenin Hospital, was an example of the redistribution of in-patient care resources that has occurred since 1959. One member of our group experienced a diabetic coma during the trip and spent several days at this hospital. He spoke highly of the treatment he received there.

Though much progress in health care delivery has been made, Cuba still has health problems. As infectious disease and malnutrition problems have come under control (incidence rates for malaria, typhoid, and diphtheria are 1, 1.5, and 5 per 100,000 respectively[2]), they have been replaced by the kinds of chronic disease more typical of the industrialized West. Heart disease and cancer are the chief causes of mortality. Despite the rationing of cigarettes and cigars (one can purchase two cigars and one pack of cigarettes every 2 weeks at a nominal price; additional cigars/cigarettes can be bought at more expensive rates), we saw many smokers. Sugar is rationed, although so liberally (6 pounds per month) that it hardly seems restrictive. The challenge of changing dietary patterns and life styles to healthier ones and raising the level of health consciousness now faces Cubans as well as Americans.

The intriguing part of Cuba's changes in the last 19 years seems to be the ability of citizens to see good health as a prerequisite to progress in most other aspects of daily life, from education, to jobs, to increasing the standard of living for everyone. Health care services are free. Cuba now has more physicians than it had before 1959, with a physician to population ratio of approximately 1 per 1,100. The World Health Organization reports infant mortality at 27 per 1,000 live births. Malaria is all but eliminated. Cuba appears to have been successful in attacking health problems for which technologic solutions existed and where elimination of such problems depended chiefly on facilitating access to medical services. By reorganizing and redistributing resources and by involving people through organized community structures, health care is presently available to a majority of citizens. Will such success continue with health problems of a much broader and more sophisticated nature typical of a more industrialized economy and for which technologic solutions presently do not exist? Cuba provides an interesting experiment which bears watching.

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A comparison is made of the incidence of hypothyroidism following surgery or I 131 therapy in patients with Graves' disease.

Comparative Follow-Up of Patients With Hyperthyroidism Treated With I 131 or Surgery

JAMSHID ALIZADEH, M.D., and JOHN A. WARD, M.D., *Atlanta

PRESENT METHODS of management of Graves' disease include antithyroid drugs, radioactive iodine, and surgery. There is still considerable debate about the relative advantages of each kind of treatment. Factors to consider include the patient's age and medical history, the presence of exophthalmos, the patient's compliance in taking medication and in keeping follow-up appointments, the availability of an experienced thyroid surgeon, and the patient's own preference of therapy. The natural history of Graves' disease is also an important factor. A recent paper[1] proposes that if the patient has good compliance in taking medications, treatment should be started with antithyroid agents and continued for 4-5 months, and within this time, up to 38% of patients will go into remission without needing further treatment. This may be an alternative to longer term drug therapy in selected patients.

Proponents of I 131 cite its low cost, the low morbidity associated with it, and the simplicity of the procedure. The possible carcinogenic effect of I 131 has been debated extensively and has been refuted.[2]

On the other hand, those who favor surgery cite the rapid results and lower incidence of hypothyroidism following surgery and point out that the morbidity in the hands of an experienced surgeon is actually very low. Furthermore with thyroidectomy for Graves' disease, the surgeon can also remove the possible malignancy, which has been reported to be as high as 9% in such glands.[3-5] In some centers in the country, the definitive treatment for patients under the age of 40 is surgery.

The purpose of this study is to compare the effect of surgery and I 131 on causing hypothyroidism patients with Graves' disease.

Methods

The study population was composed of patients with Graves' disease who had been treated with I 131 or surgery at the Veterans Administration Hospital in Decatur since 1966. Definitive treatment for thyrotoxicosis was given after the patients were euthyroid on drug therapy. Patients over 40 years of age made their own choices, provided there was no contraindication to surgery. Patients under 40 years of age were treated surgically.

Surgery was done by the senior surgical resident with the supervision of an attending surgeon. The dose of I 131 was determined and administered by the Department of Nuclear Medicine according to the size and uptake of the gland.

PBI's were measured by the Barker and Humphreys method. T3 resin uptake, T4, and thyroid stimulating hormone (TSH) were measured by radioimmunoassay by Bio-rad. Antibodies to thyroglobulin and microsomes were measured by Ames method.

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Results

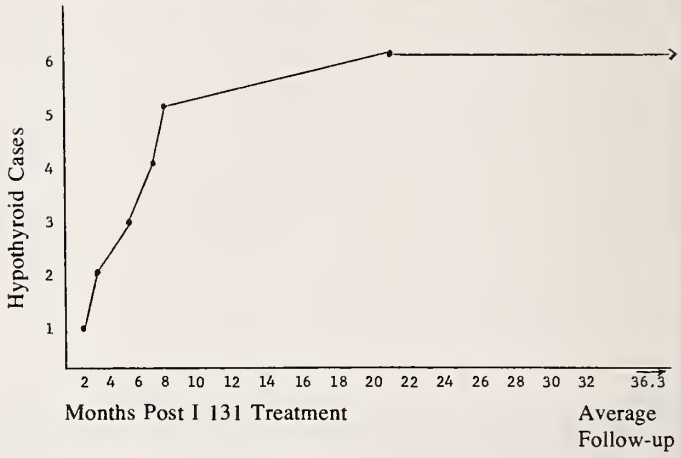
There were 22 patients in the study. Eleven were treated with I 131 and 11 with surgery. The average follow-up period for I 131 patients was 36.3 months (Table 1). At the time of the study, six of the 11 (54.5%) were taking thyroid replacement medication because of documented hypothyroidism. The average period between treatment and development of hypothyroidism was 7.6 months. Hypothyroidism occurred within the first 8 months after treatment in five out of six patients. In the other five patients who remained euthyroid, the average post treatment follow-up was 45.2 months. Thyroid antibodies were measured in eight of the 11 patients before giving them I 131. Four had positive antibodies. Three of these became hypothyroid after the treatment.

Table 2 shows the follow-up of the 11 patients who were treated surgically. The average follow-up period was 43.5 months. Four of these patients became hyperthyroid (36.3%); the average time before onset was 2 months. In the other seven patients who are still euthyroid, the average follow-up was 49.4 months.

All but two surgically-treated patients either euthyroid or hypothyroid had at least one positive thyroid antibody (measured after surgery).

Figure 1 shows that most of hypothyroidism following I 131 occurs within 8 months after the treatment. Figure 2 shows that in all surgically treated patients, hypothyroidism occurred within 3 months after surgery.

FIGURE 1
NUMBER OF HYPOTHYROID CASES OCCURRING BY LENGTH OF TIME FOLLOWING I 131 THERAPY



Conclusion and Comment

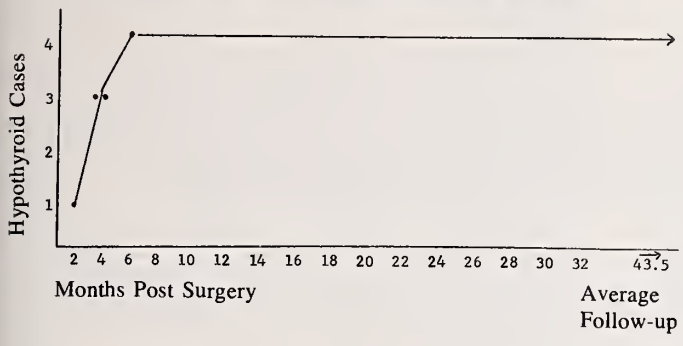
Hypothyroidism following surgery usually occurs more quickly (compare Figures 1 and 2) but in a lower percentage of patients (36.3% and 54.5%, respectively). Because of small sample, however, this difference is not statistically significant (P = 0.75). The reported incidence of hypothyroidism following surgery has been reported between 3% to 49%.[6-9] One attempt was made to relate the incidence of hypothyroidism with remnant size of thyroid gland,[7, 10] but this opinion has been refuted.[11-13] An interesting feature is the temporal relationship between surgery and the occurrence of hypothyroidism. Some authors[7, 14] report that

TABLE 1
FOLLOW-UP DATA ON PATIENTS WITH GRAVES' DISEASE TREATED WITH I 131

Name	T_4 Before Treatment	Antibodies: Anti Microsomal	Antibodies: Anti Thyroglobulin	Date of Treatment	Dose of I 131 (Millicurie)	Date of Last Test	Months of Follow-up	Period Between Treatment and Hypothyroidism	Meds	Last T_4	Last TSH
F.H.	>20*	1/100	Negative	9-15-76	8.36	8-26-77+	11	—	None	6.8*	Not Done
F.C.	>20*	Negative	Negative	11-12-75	11.02	9-21-77+	22	—	None	5.6*	3.9§
J.D.	PBI = 14.2†	Not done	Not done	8-16-66	9.6	9-6-77+	133	—	None	5.8*	3.5§
G.D.	19.5*	Negative	Negative	4-28-76	9.16	6-28-77+	14	—	None	8.2*	3.7§
S.L.	18*	Not done	Not done	11-8-73	8.5	9-6-77+	46	—	None	8.4*	1.8§
J.L.	15*	Not done	Not done	11-29-73	7.94	1-22-74++	45	2	Thyroid	3.6*•	Not done
G.H.	19.9*	Not done	Not done	8-19-75	7.34	5-17-77++	23	21	Thyroid	4.2*•	10.5§•
R.S.	19.7*	Negative	1/6400	9-15-76	8.40	12-21-76++	12	3	Thyroid	3.4*•	40§•
J.R.	20.8*	1/1600	1/100	8-19-75	8.17	3-4-76++	25	7	Thyroid	2.5*•	24.8§•
H.L.	16.2*	1/25	Negative	8-14-74	7.2	4-18-75++	36	8	Thyroid	0.6*•	Not done
J.W.	19*	Negative	Negative	12-11-74	8.51	4-9-75++	33	5	Thyroid	4.7*•	13§•

* = normal: 5-12 mcg/100 cc; † = normal: 3.5-9 mcg/100 cc; ‡ = normal 3.5-8 mcg/100 cc; § = normal 1-9 micro unit/ml; + = date of the last test; ++ = date of discovering hypothyroidism; • = tests confirming hypothyroidism.

FIGURE 2
NUMBER OF HYPOTHYROID CASES OCCURRING BY LENGTH OF TIME FOLLOWING SURGERY



hypothyroidism occurs within the first few months after surgery; but others[15, 16] report the gradually increasing incidence of hypothyroidism as the length of time after surgery increases. The results of our study are consistent with those of Olsen et al.[14]

As for patients who were treated with I 131, the incidence of hypothyroidism was reported as 70% in 10 years;[16] 2.4% in 4 years,[17] and 29% in 10 years.[18] Although the majority of cases of hypothyroidism occur in the first years post I 131 therapy, there is an annual accumulative incidence of 2.8%.[16]

The recurrence of hyperthyroidism, which has been reported 8-9% in both I 131 and surgically-treated patients,[18] did not occur in our patients. High TSH levels in clinically euthyroid patients after thyroidectomy are reported as 11%,[15] 53%,[19] and 40%[20] of the patients. This elevation could be temporary.[21] In our euthyroid, post-surgical patients, when TSH was measured, this elevation was not noted (Table 2). We were unable to correlate positive antibody titers with lymphocyte infiltration of the gland. Several authors[7, 18] have tried to make such correlations.

Comparison between these two different methods of treatment of Graves' disease for the patients who are not candidates for long-term antithyroid medications has been made by different authors.[2, 22] There is nothing in our study to disagree with the conclusion of Crile et al.[2] which states, "we continue to regard radioactive iodine as the most effective and probably the safest treatment for hyperthyroidism." It is also the least expensive for definitive treatment. However, 62% of the surgically treated group were euthyroid for an average follow-up of 49.4 months, compared to 45.5% of those treated with I 131, for an average follow-up of 45.2 months.

TABLE 2
FOLLOW-UP DATA ON PATIENTS WITH GRAVES' DISEASE TREATED WITH SURGERY

Name	T_4 Before Surgery	Antibodies: Microsomal	Antibodies: Thyroglobulin	Date of Surgery	Pathology Report	Date of Last Test	Follow-up Months	Period Between Surgery and Hypothyroidism	Meds	Last T_4	Last TSH
W.P.	PBI:13†	1/1600	Negative	1-26-70	Adenomatous goiter	2-8-78+	97	—	None	8.9*	4.4§
J.S.	PBI:13.5†	1/25,600	1/400	1-29-74	Toxic hyperplasia	2-8-78+	49	—	None	10.6*	1.4§
L.G.	19.5*	1/400	Negative	5-31-77	Hyperplasia	2-8-78+	8	—	None	8.2*	4.9§
W.M.	10‡	1/6400	1/400	5-23-76	Hyperplasia	2-8-78+	21	—	None	9.7*	2.1§
C.C.	15.8*	1/400	Negative	3-31-72	Hyperplasia, Diffuse lymph infiltration	2-8-78+	46	—	None	9.1*	4§
C.M.	PBI:17.1†	1/25,600	1/1600	11-18-69	Hyperplasia	2-8-78+	99	—	None	9.29*	10§
M.W.	>26*	1/400	1/400	12-5-75	Micro-nodular goiter	2-7-78+	26	—	None	8.8*	5.5§
J.J.	11.9‡	Negative	Negative	8-17-73	Involutional + Lymphocyte	10-24-73++	54	2	Thyroid	3.7*•	42.2§•
H.S.	16.1*	1/1600	Negative	12-29-75	Involutional hyperplasia	3-9-76++	26	3	Thyroid	2.2*•	40§•
T.M.	22.3*	1/400	Negative	12-19-75	Involutional hyperplasia	1-28-76++	26	1	Thyroid	1.3*•	34.5§•
L.W.	23*	Not done	Not done	11-14-75	Adenomatous goiter	1-27-76++	27	2	Thyroid	1.3*•	21§•

* = normal: 5-12 mcg/100 cc; † = normal: 3.5-9 mcg/100 cc; ‡ = normal 3.5-8 mcg/100 cc; § = normal 1-9 micro unit/ml; + = date of the last test; ++ = date of discovering hypothyroidism; • = tests confirming hypothyroidism.

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Brief Summary
INDICATION: Tenuate and Tenuate Dospan are indicated in the management of exogenous obesity as a short-term adjunct (a few weeks) in a regimen of weight reduction based on caloric restriction. The limited usefulness of agents of this class should be measured against possible risk factors inherent in their use such as those described below.
CONTRAINDICATIONS: Advanced arteriosclerosis, hyperthyroidism, known hypersensitivity, or idiosyncrasy to the sympathomimetic amines, glaucoma. Agitated states. Patients with a history of drug abuse. During or within 14 days following the administration of monoamine oxidase inhibitors, (hypertensive crises may result).
WARNINGS: If tolerance develops, the recommended dose should not be exceeded in an attempt to increase the effect; rather, the drug should be discontinued. Tenuate may impair the ability of the patient to engage in potentially hazardous activities such as operating machinery or driving a motor vehicle; the patient should therefore be cautioned accordingly. *Drug Dependence:* Tenuate has some chemical and pharmacologic similarities to the amphetamines and other related stimulant drugs that have been extensively abused. There have been reports of subjects becoming psychologically dependent on diethylpropion. The possibility of abuse should be kept in mind when evaluating the desirability of including a drug as part of a weight reduction program. Abuse of amphetamines and related drugs may be associated with varying degrees of psychologic dependence and social dysfunction which, in the case of certain drugs, may be severe. There are reports of patients who have increased the dosage to many times that recommended. Abrupt cessation following prolonged high dosage administration results in extreme fatigue and mental depression; changes are also noted on the sleep EEG. Manifestations of chronic intoxication with anorectic drugs include severe dermatoses, marked insomnia, irritability, hyperactivity, and personality changes. The most severe manifestation of chronic intoxications is psychosis, often clinically indistinguishable from schizophrenia. *Use in Pregnancy:* Although rat and human reproductive studies have not indicated adverse effects, the use of Tenuate by women who are pregnant or may become pregnant requires that the potential benefits be weighed against the potential risks. *Use in Children:* Tenuate is not recommended for use in children under 12 years of age.
PRECAUTIONS: Caution is to be exercised in prescribing Tenuate for patients with hypertension or with symptomatic cardiovascular disease, including arrhythmias. Tenuate should not be administered to patients with severe hypertension. Insulin requirements in diabetes mellitus may be altered in association with the use of Tenuate and the concomitant dietary regimen. Tenuate may decrease the hypotensive effect of guanethidine. The least amount feasible should be prescribed or dispensed at one time in order to minimize the possibility of overdosage. Reports suggest that Tenuate may increase convulsions in some epileptics. Therefore, epileptics receiving Tenuate should be carefully monitored. Titration of dose or discontinuance of Tenuate may be necessary.
ADVERSE REACTIONS: *Cardiovascular:* Palpitation, tachycardia, elevation of blood pressure, precordial pain, arrhythmia. One published report described T-wave changes in the ECG of a healthy young male after ingestion of diethylpropion hydrochloride. *Central Nervous System:* Overstimulation, nervousness, restlessness, dizziness, jitteriness, insomnia, anxiety, euphoria, depression, dysphoria, tremor, dyskinesia, mydriasis, drowsiness, malaise, headache; rarely psychotic episodes at recommended doses. In a few epileptics an increase in convulsive episodes has been reported. *Gastrointestinal:* Dryness of the mouth, unpleasant taste, nausea, vomiting, abdominal discomfort, diarrhea, constipation, other gastrointestinal disturbances. *Allergic:* Urticaria, rash, ecchymosis, erythema. *Endocrine:* Impotence, changes in libido, gynecomastia, menstrual upset. *Hematopoietic System:* Bone marrow depression, agranulocytosis, leukopenia. *Miscellaneous:* A variety of miscellaneous adverse reactions has been reported by physicians. These include complaints such as dyspnea, hair loss, muscle pain, dysuria, increased sweating, and polyuria.
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Product Information as of April, 1976

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References: 1. Citations available on request—Medical Research Department, MERRELL RESEARCH CENTER, MERRELL-NATIONAL LABORATORIES, Cincinnati, Ohio 45215. 2. Hoekenga, M.T., O'Dillon, R.H., and Leyland, H.M.: A Comprehensive Review of Diethylpropion Hydrochloride. International Symposium on Central Mechanisms of Anorectic Drugs, Florence, Italy, Jan. 20-21, 1977.

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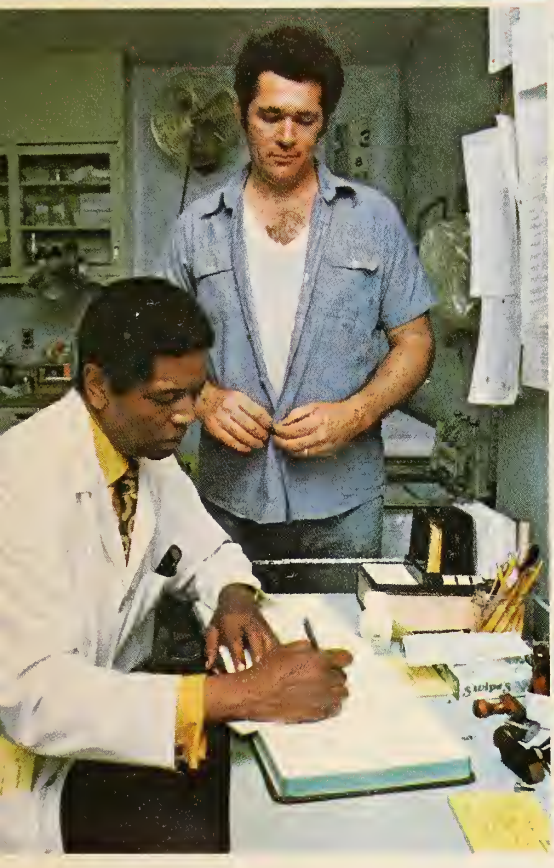
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The 6,000,000 patients already treated with Motrin is an objective measure of physicians' confidence in the ability of Motrin to relieve the pain and inflammation associated with rheumatoid arthritis and osteoarthritis.

So it is not surprising that in this short period Motrin has become the most frequently prescribed alternative to aspirin. Motrin relieves joint pain and inflammation as effectively as indomethacin or aspirin, but causes significantly fewer CNS and milder GI reactions. However, gastrointestinal bleeding, sometimes severe, has been associated with Motrin, aspirin, indomethacin, and other nonsteroidal antiarthritic agents.

*The safety and effectiveness of Motrin have not been established in patients with Functional Class IV rheumatoid arthritis (incapacitated, largely or wholly bedridden, or confined to wheelchair; little or no self-care).

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Motrin 400 mg TABLETS
ibuprofen, Upjohn

The confidence that comes from experience—one more reason to prescribe Motrin.

Please turn page for a brief summary of prescribing information.

Upjohn The Upjohn Company, Kalamazoo, Michigan 49001

J-6857-4

The confidence that comes from experience—
one more reason to prescribe

Motrin 400 mg TABLETS
ibuprofen, Upjohn

Indications and Usage: Treatment of signs and symptoms of rheumatoid arthritis and osteoarthritis during acute flares and in long-term management. Safety and efficacy have not been established in Functional Class IV rheumatoid arthritis.

Contraindications: Individuals hypersensitive to it, or with the syndrome of nasal polyps, angioedema and bronchospastic reactivity to aspirin or other nonsteroidal anti-inflammatory agents (see WARNINGS).

Warnings: Anaphylactoid reactions have occurred in patients with aspirin hypersensitivity (see CONTRAINDICATIONS).

Peptic ulceration and gastrointestinal bleeding, sometimes severe, have been reported. Ulceration, perforation, and bleeding may end fatally. An association has not been established. Motrin should be given under close supervision to patients with a history of upper gastrointestinal tract disease, only after consulting ADVERSE REACTIONS.

In patients with active peptic ulcer and active rheumatoid arthritis, nonulcerogenic drugs, such as gold, should be tried. If Motrin must be given, the patient should be under close supervision for signs of ulcer perforation or gastrointestinal bleeding.

Precautions: Blurred and/or diminished vision, scotomata, and/or changes in color vision have been reported. If these develop, discontinue Motrin and the patient should have an ophthalmologic examination, including central visual fields.

Fluid retention and edema have been associated with Motrin; use with caution in patients with a history of cardiac decompensation.

Motrin can inhibit platelet aggregation and prolong bleeding time. Use with caution in persons with intrinsic coagulation defects and those on anticoagulant therapy.

Patients should report signs or symptoms of gastrointestinal ulceration or bleeding, blurred vision or other eye symptoms, skin rash, weight gain, or edema.

To avoid exacerbation of disease or adrenal insufficiency, patients on prolonged corticosteroid therapy should have therapy tapered slowly when Motrin is added.

Drug interactions. *Aspirin* used concomitantly may decrease Motrin blood levels. *Coumarin:* Bleeding has been reported in patients taking Motrin and coumarin.

Pregnancy and nursing mothers: Motrin should not be taken during pregnancy or by nursing mothers.

Adverse Reactions

Incidence greater than 1%

Gastrointestinal: The most frequent type of adverse reaction occurring with Motrin (ibuprofen) is gastrointestinal (4% to 16%). This includes nausea*, epigastric pain*, heartburn*, diarrhea, abdominal distress, nausea and vomiting, indigestion, constipation, abdominal cramps or pain, fullness of the GI tract (bloating and flatulence). **Central Nervous System:** Dizziness*, headache, nervousness. **Dermatologic:** Rash* (including maculopapular type), pruritus. **Special Senses:** Tinnitus. **Metabolic:** Decreased appetite, edema, fluid retention. Fluid retention generally responds promptly to drug discontinuation (see PRECAUTIONS).

Incidence: Unmarked 1% to 3%; *3% to 9%.

Incidence less than 1 in 100

Gastrointestinal: Upper GI ulcer with bleeding and/or perforation, hemorrhage, melena. **Central Nervous System:** Depression, insomnia. **Dermatologic:** Vesiculobullous eruptions, urticaria, erythema multiforme. **Cardiovascular:** Congestive heart failure in patients with marginal cardiac function, elevated blood pressure. **Special Senses:** Amblyopia (see PRECAUTIONS). **Hematologic:** Leukopenia, decreased hemoglobin and hematocrit.

Causal relationship unknown

Gastrointestinal: Hepatitis, jaundice, abnormal liver function. **Central Nervous System:** Paresthesias, hallucinations, dream abnormalities. **Dermatologic:** Alopecia, Stevens-Johnson syndrome. **Special Senses:** Conjunctivitis, diplopia, optic neuritis. **Hematologic:** Hemolytic anemia, thrombocytopenia, granulocytopenia, bleeding episodes. **Allergic:** Fever, serum sickness, lupus erythematosus syndrome. **Endocrine:** Gynecomastia, hypoglycemia. **Cardiovascular:** Arrhythmias. **Renal:** Decreased creatinine clearance, polyuria, azotemia.

Overdosage: In cases of acute overdosage, the stomach should be emptied. The drug is acidic and excreted in the urine, so alkaline diuresis may be beneficial.

Dosage and Administration: Suggested dosage is 300 or 400 mg t.i.d. or q.i.d. Do not exceed 2400 mg per day.

How Supplied

Motrin Tablets, 300 mg (white)	
Bottles of 60	NDC 0009-0733-01
Bottles of 500	NDC 0009-0733-02
Motrin Tablets, 400 mg (orange)	
Bottles of 60	NDC 0009-0750-01
Bottles of 500	NDC 0009-0750-02
Unit-dose package of 100	NDC 0009-0750-06
Unit of Use bottles of 120	NDC 0009-0750-26

Caution: Federal law prohibits dispensing without prescription.

NIM-3

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MSD MERCK SHARP & DOHME

125th MAG Annual Session

Official Call

To the officers, delegates, and members of the Medical Association of Georgia

To Attend the Meeting of The House of Delegates in Savannah, April 20-22, 1979

The House of Delegates will convene at 10:00 a.m. on Friday, April 20, in the North and Center Ballrooms of the De Soto Hilton. The House of Delegates will be preceded by a General Session of Association Members at 9:00 a.m.

This Annual Session will confine itself to the business affairs of the Association. By House of Delegates action in 1973, the scientific portion of the meeting was separated from the business portion and is held in November of each year.

Hotel Reservations

Officers, directors, and delegates will have first priority for rooms at the De Soto Hilton. MAG also has a room block at the Downtowner and the Ramada Inn. Please use an official housing form on page 121 or write directly to the hotel of your choice.

Registration

Registration facilities will be maintained in the foyer outside the North and Center Ballrooms for delegates, alternate delegates, directors, and all members. Registration hours will be as follows:

Thursday, April 19 4 p.m.-7 p.m.
Friday, April 20 7:30 a.m.-12:00 noon
Saturday, April 21 ... 8:30 a.m.-5:00 p.m.
(After 12 noon, please come to MAG Headquarters office.)
Sunday, April 22 7:00 a.m.-12 noon

Headquarters Office

The Association staff will maintain an office just off the foyer of the De Soto Hilton.

Message Center

The Auxiliary to the MAG will maintain a message desk in the lobby of the De Soto Hilton for the convenience of the membership. Names displayed on a projection screen in the House of Delegates will alert the members of an incoming message. The messages will be posted on a bulletin board at the message desk in the foyer.

General Sessions

The opening General Session will be called to order by the president, Carson B. Burgstiner, M.D., on Friday, April 20, at 9:00 a.m., in the North and Center Ballrooms of the De Soto Hilton. Featured during this opening ceremony will be the presentation of the report of the President of the Auxiliary to MAG.

There will be no General Session on Saturday.

The Second General Session will be held following adjournment of the House of Delegates on Sunday, April 22. At this time, the newly-elected officers will be installed.

House of Delegates

The first session of the House of Delegates will convene on Friday, April 20, at 10:00 a.m. in the North and Center Ballrooms of the De Soto Hilton. At this time, nominations for MAG officers will be made. Reports of officers and committees will be presented. Resolutions and other new business will be placed before the House. Reference committees will be appointed and all resolutions and reports will be referred by the speaker to the appropriate reference committees.

The second session of the House of Delegates will convene at 10:00 a.m. on Saturday, April 21, in the North and Center Ballrooms. Reference committees will report to the House at this time.

The third and final session of the House of Delegates will convene at 9:00 a.m. on Sunday, April 22, at which time the results of the election of officers will be announced and the remaining Reference Committee reports will be presented.

Reference Committees

According to the Bylaws of the Association, all resolutions and reports which contain recommendations must be referred to reference committees for open hearings. All members are invited and encouraged to appear before the reference committees to express their views. The reference committees

will open their hearings on Friday, April 20, 2 hours following the recess of the House of Delegates, or approximately 1:00 p.m., subject to announcement by the speaker.

Election of Officers

Nominations for the officers of the Association will be made during the first session of the House of Delegates on Friday, April 20. The election will take place before the House of Delegates, Sunday, April 22. Delegates will be certified by members of the Credentials Committee and receive their ballots at that time. Voting will be done in appropriate voting booths. After the polls close at 9:00 a.m., the Tellers Committee will count the ballots and the results will be announced at the General Session following the adjournment of the House of Delegates. If it is necessary to have a run-off election, it will be held during the House meeting.

GaMPAC

There will be no GaMPAC brunch at this year's meeting.

President's Reception and Banquet

The Association will honor its president at a reception to be held at 6:30 p.m., Saturday, April 21, followed by the Awards Banquet. Also featured at this banquet will be addresses by Tom E. Nesbitt, M.D., Nashville, Tennessee, President of the American Medical Association, and Carson B. Burgstiner, M.D., MAG President. All members and their guests are invited to attend.

Alumni Events

Receptions and dinners sponsored by the various medical school alumni organizations are often held during the Annual Session. Notice will be made prior to the Annual Session.

AMA PRESIDENT TOM E. NESBITT, M.D.



Tom E. Nesbitt, M.D., 1978-79 President of the American Medical Association (AMA), will be the guest speaker at the president's reception and banquet on Saturday, April 21. Dr. Nesbitt specializes in urology in Nashville, Tennessee, where he is a partner of Urology Associates. Dr. Nesbitt started his practice in Nashville in 1957. Prior to his election at the 1977 Annual Convention in St. Louis, he served as the speaker of the AMA's policy-making House of Delegates from 1973 until 1977, when he was elected President-elect of the American Medical Association.

Long active in medical society activities, Dr. Nesbitt is a past speaker of the Tennessee Medical Association's House of Delegates, and the past president of the Tennessee Medical Association. He was a delegate to the AMA from the Tennessee Medical Association in 1967-1977, was a former member of the Committee on Private Practice of the American Medical Association, and has been a member of several reference committees. In 1971, he was elected to the presidency of the American Association of Clinical Urologists, and he has also been, until 1977, a member of the National Advisory Council on Graduate Medical Education to the Secretary of the Department of Health, Education, and Welfare.

Dr. Nesbitt has also been active in community affairs in his home town of Nashville, Tennessee. He has served on the Board of Governors of the Nashville Chamber of Commerce and the State of Tennessee Medical Advisory Committee on Medicaid. He is a member and former chairman of the Board of Deacons of the First Presbyterian Church in Nashville.

He has four children, Tom Jr., who is an M.D., and a daughter Mary, who is a registered nurse. His youngest son, Jonathan, is a second-year medical student at Georgetown University School of Medicine, and his daughter Elizabeth is a senior at Vanderbilt University School of Nursing.

Dr. Nesbitt is the seventh Tennessean to serve as president of the American Medical Association. His speech this year during the president's reception and banquet promises to be enlightening and inspiring and is certain to be a highlight of this year's 125th MAG Annual Session.

Officers of the Association

1978-1979


BURGSTINER


ATKINS


JOHNSON


STUBBS


TURK


LOGAN


SULLIVAN


GRIFFIN


BUCHANAN


MENENDEZ


WOODY

OFFICERS

Position		*Term Ending*
PRESIDENT	Carson B. Burgstiner, Savannah	1979
PRESIDENT-ELECT	Earnest C. Atkins, Atlanta	1979
IMMEDIATE PAST PRESIDENT	Milton I. Johnson, Macon	1979
PAST PRESIDENT	Fleming L. Jolley, Atlanta	1980
PAST PRESIDENT	David A. Wells, Dalton	1979
CHAIRMAN OF THE BOARD OF DIRECTORS	Joe C. Stubbs, Valdosta	1979
FIRST VICE PRESIDENT	L. Newton Turk III, Atlanta	1979
SECOND VICE PRESIDENT	Richard A. Griffin III, Cartersville	1979
VICE CHAIRMAN, BOARD OF DIRECTORS	Jack A. Raines, Columbus	1979
SECRETARY	William D. Logan Jr., Atlanta	1981
TREASURER	James H. Sullivan, Columbus	1981
SPEAKER OF THE HOUSE	L. C. Buchanan, Decatur	1980
VICE SPEAKER OF THE HOUSE	Jack Menendez, Macon	1980
EDITOR, *JMAG*	Edgar Woody Jr., Atlanta	1979

Component County Society Representation to the 1979 House of Delegates

(1978 CMS Member Count for 1979 Delegates to Annual Session—Tentative)

County Medical Society	Number of Delegates
Altamaha	1
Baldwin	2
Barrow	1
Bartow	1
Ben Hill-Irwin	1
Bibb	9
Ogeechee River	2
Burke	1
Carroll-Douglas-Haralson	2
Georgia Medical Society	10
Elbert	1
Chattahoochee	2
Cherokee-Pickens	1
Crawford W. Long	4
Clayton-Fayette	3
Cobb	11
Coffee	1
Colquitt	1
Coweta	1
Decatur-Seminole	1
DeKalb	12
Dougherty	4
Camden-Charlton	1
Emanuel	1
Flint	1
Floyd-Polk-Chattooga	5
Franklin	1
Medical Association of Atlanta	49
Glynn	3
Gordon	1
Habersham	1
Hall	4
Peach Belt	2
Jackson-Banks	1
Jefferson	1
Laurens	2
McDuffie	1
Meriwether-Harris-Talbot	1
Mitchell	1
Muscogee	9
Newton-Rockdale	1
Oconee Valley	1
Ocmulgee	1
Randolph-Stewart-Terrell	1
Richmond	14
Screven	1
South Georgia	3
Southeast Georgia	1
Southwest Georgia	1
Spalding	2
Stephens-Rabun	1
Sumter	1
St. John's Parish	1
Telfair	1
Thomas Area	3
Tift	1
Troup	2
Upson	2
Walker-Catoosa-Dade	2
Walton	1
Ware	2
Washington	1
Wayne	1
Whitfield-Murray	3
Wilkes	1
Worth	1

Criteria for Selection of Recipients of MAG Awards

Hardman Cup

This award is presented for "the active achievement of anyone who in the judgment of the Association has solved any outstanding problem in public health or made any discovery in medicine or surgery" or such contribution to the science of medicine. The recipient of this award will be selected by a five-man secret committee. Nominations for this award are to be made by component county medical societies, and all nominations must be accompanied by supporting biographical data and received at MAG Headquarters no later than March 1. If no nominations and supporting data are received, no award will be made. No nominations for this award will be accepted from the floor. If given, this award will be presented on Saturday, April 21. By custom, this award usually has gone to a Georgia physician; however, this is not required by the terms of the letter from Governor Hardman establishing this award.

Distinguished Service

The Distinguished Service Award is presented for distinguished and meritorious service which reflects

credit and honor on the Association. Nominations for this award should be made by component county medical societies and must be received at MAG Headquarters no later than March 1. They must be accompanied by biographical data supporting the nomination. The recipient will be selected by a five-man secret committee and presentation will be made on Saturday, April 21.

Civic Endeavor Award

This award, presented for the first time at the 1969 Annual Session, will be given pursuant to an action taken by the 1968 House of Delegates in Augusta. This award is to be given for outstanding public service and participation in civic activities. Component county medical societies are invited to make nominations for this award supported by appropriate data which must be received at MAG Headquarters no later than March 1. The recipient of this award will be selected by a three-man secret committee which will determine if the nominees meet the requirements of the resolution which created this award. Presentation will be made on Saturday, April 21.

Family Physician of the Year

This award is presented to an outstanding family physician in Georgia. Selection of the recipient is made by the Board of Directors of the Georgia Academy of Family Physicians and presentation of the award is made during the Annual Session. The president of the Georgia Academy of Family Physicians (or his designee in the event of his absence) will present this award on Saturday, April 21.

DIRECTORS AND ALTERNATE DIRECTORS

District	Director	Alternate Director	Term Ending
1	Leon E. Curry, Metter	Charles R. Richardson, Statesboro	1979
2	J. Dan Bateman, Albany	Sammie Dixon, Tifton	1979
3	John H. Robinson, Americus	B. Lamar Pilcher, Warner Robins	1979
6	James M. Skinner, Griffin	Norman P. Gardner, Thomaston	1980
7	Richard A. Griffin III, Cartersville	D. R. Mahan, Dalton	1980
8	Joe C. Stubbs, Valdosta	Michel A. Glucksman, Brunswick	1980
9	Rupert H. Bramblett, Cumming	L. Austin Flint, Canton	1981
10	M. A. Hubert, Athens	Wm. M. Headley, Milledgeville	1981
Bibb County Medical Society			
	Beverly B. Sanders, Macon	Rodney M. Browne, Macon	1981
Cobb County Medical Society			
	Charles R. Underwood, Marietta	Frank W. McKinnon, Marietta	1981
DeKalb Medical Society			
	John P. Heard, Decatur	Roy W. Vandiver, Decatur	1981
Floyd-Polk-Chattooga Medical Society			
	John I. Dickinson, Rome	Robert A. Farrell, Rome	1981
Medical Association of Atlanta			
	John T. Godwin, Atlanta	J. Norman Berry, Sandy Springs	1980
	T. J. Anderson Jr., Atlanta	William C. Collins, Atlanta	1980
	J. Harold Harrison, Atlanta	William C. Waters III, Atlanta	1979
Georgia Medical Society			
	Joseph A. Mulherin, Savannah	Joe L. Nettles, Savannah	1979
Muscogee County Medical Society			
	Jack A. Raines, Columbus	E. M. Molnar, Columbus	1980
Richmond County Medical Society			
	Ronald F. Galloway, Augusta	Luther M. Thomas, Augusta	1981

AMA DELEGATES AND ALTERNATE DELEGATES, JANUARY 1, 1979

Delegates	Term Ending	Alternate Delegates	Term Ending
C. Emory Bohler, Brooklet	12-31-79	F. G. Eldridge, Valdosta	12-31-79
F. W. Dowda, Atlanta	12-31-79	Charles D. Hollis, Albany	12-31-79
Harrison L. Rogers Jr., Atlanta	12-31-80	H. Hilt Hammett, La Grange	12-31-80
J. Dan Bateman, Albany	12-31-80	W. W. Moore, Atlanta	12-31-80

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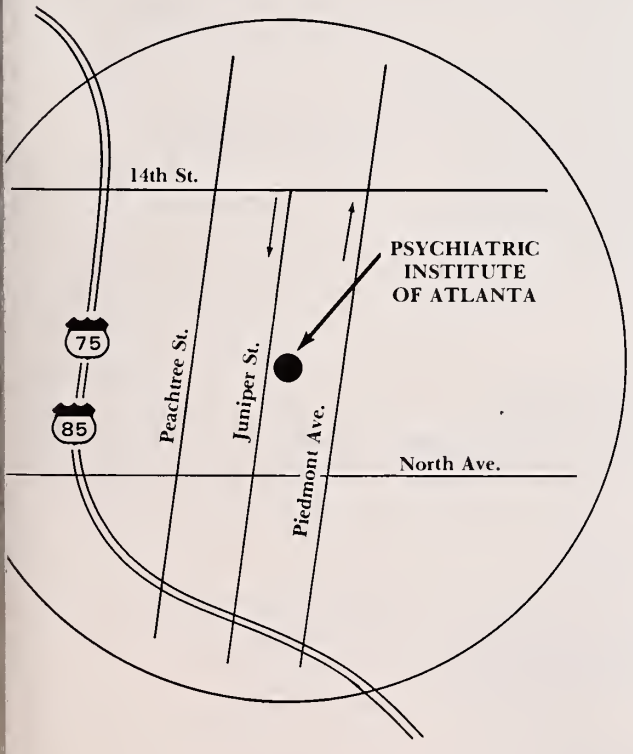
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Official Program

(All functions of the House of Delegates will be held in the De Soto Hilton)

THURSDAY, APRIL 19

4:00-7:00 p.m.	**General and Delegates Registration** *Foyer*

FRIDAY, APRIL 20

7:30 a.m.	**General and Delegates Registration** *Foyer*
9:00 a.m.	**General Session** *North and Center Ballrooms*
	Presiding: Carson B. Burgstiner, M.D., President
	Opening Ceremonies
	Report of the President of the Auxiliary to the Medical Association of Georgia, Mrs. Robert S. McMichael, of Macon
	Announcements
	Recess
10:00 a.m.	**House of Delegates**
	North and Center Ballrooms
	Presiding: L. C. Buchanan, M.D., Speaker, and Jack F. Menendez, M.D., Vice Speaker
	Presentation, Correction, and Adoption of the Minutes of the 1978 House of Delegates
	Appointment of Convention Committees
	Nominations for Association Officers and AMA Delegates
	Reports of Officers and Committees
	Introduction of New Business
	Announcements
	Recess
1:00 p.m.	**Reference Committee Hearings** *North Ballroom, James Madison Room, North and South Harbor View Rooms, Pulaski Room, 17-18 Room*

SATURDAY, APRIL 21

8:30 a.m.	**General and Delegates Registration** *Foyer*
10:00 a.m.	**House of Delegates, Second Session** *North and Center Ballrooms*

6:30 p.m.	**President's Reception and Banquet** *North and Center Ballrooms* Presentation of Association Awards Family Physician of the Year Hardman Cup Civic Endeavor Award Distinguished Service Award Addresses by: Tom E. Nesbitt, M.D., President, American Medical Association and Carson B. Burgstiner, M.D. (All MAG members, Auxiliary members, and guests are cordially invited)

SUNDAY, APRIL 22

7:00 a.m.	**General and Delegates Registration** *Foyer*
7:00 a.m.-9:00 a.m.	**Polls Open for Election of Association Officers and AMA Delegates** *Foyer*
9:00 a.m.	**House of Delegates, Third and Final Session** *North and Center Ballrooms* Presiding: L. C. Buchanan, M.D., Speaker, and Jack F. Menendez, M.D., Vice Speaker Invocation Reports of Reference Committees Announcements Announcements of Election Results Adjournment of House of Delegates
12:00 Noon	**General Session, Final** *North and Center Ballrooms* Presiding: Carson B. Burgstiner, M.D., President Installation of Officers Adjournment of 125th Annual Session

Welcome to Savannah

To the Members of the Medical Association of Georgia:

On behalf of the Georgia Medical Society, I would like to extend to you an invitation to attend the meeting of the House of Delegates April 20-22, 1979, at the De Soto Hilton in Savannah.

J. Robert Logan, M.D.
President, Georgia Medical Society

54th Auxiliary Annual Convention

April 19-21, 1979 • De Soto-Hilton • Savannah, Georgia





President's Greeting

HISTORIC SAVANNAH will be the site of the Annual Meeting of the Auxiliary-MAG on April 19-21, 1979. All auxiliary members are invited and encouraged to attend.

The De Soto-Hilton will be headquarters this year for both the Auxiliary and the Medical Association conventions, so make your reservations early. Additional accommodations for an overflow crowd may be found at the nearby Downtowner Motel.

Mrs. Wayne C. Brady of Greenville, South Carolina, a member of the Board of Directors of the Auxiliary to the American Medical Association, will be our special guest. We hope to present the right combination of business and pleasure to make these days enjoyable and worthwhile.

The Georgia Medical Auxiliary is the host auxiliary for our meeting. The hospitality of this group was well expressed in the words of Convention Chairman, Sandee (Mrs. Robert H.) Carter,

"We love to have company in Savannah." Georgia Medical will be assisted by two co-hosts, the Cherokee-Pickens and Clayton-Fayette Auxilaries.

Come join us in romantic Savannah in the Spring.

MRS. ROBERT S. MCMICHAEL
President, Auxiliary to the Medical Association of Georgia

Welcome to Savannah

SAVANNAH is a beautiful place to visit anytime of the year, but April is especially lovely. The Auxiliary to the Georgia Medical Society hopes you will take advantage of the opportunity to come here to the 54th convention of the Medical Association of Georgia. There will be well-planned thought-provoking meetings, so plan to attend them. Don't forget to bring your tennis racket, golf clubs, running shoes, beach towels, a good book, or whatever paraphernalia you need for enjoying your leisure time, too.

Have your spouse make his/her plans to come, as we will have activities planned for them.

See you April 19-20-21!

SHARON C. LYNCH
(Mrs. Lawrence J., Jr.)
President
Auxiliary to Georgia Medical Society

1979 Auxiliary Annual Convention Schedule

THURSDAY, APRIL 19	EVENT	LOCATION
2:00 p.m.-5:00 p.m.	Registration and Information	Foyer
2:00 p.m.-5:00 p.m.	Hospitality and Exhibits	Foyer
3:00 p.m.-4:00 p.m.	Pre-Convention Executive Board Meeting	South Harbor View Room
4:00 p.m.-5:00 p.m.	Orientation 1979-1980	North Harbor View Room
6:30 p.m.-7:30 p.m.	Reception for 1978-1979 Executive Board	Harbor View Room
FRIDAY, APRIL 20		
8:30 a.m.-5:00 p.m.	Registration and Information	Foyer
8:30 a.m.-5:00 p.m.	Hospitality and Exhibits	Foyer
9:00 a.m.-10:00 a.m.	MAG General Session Auxiliary President's Address Introduction of Guests	North and Center Ballroom South Ballroom
10:30 a.m.-12:00 Noon	First General Session Guest Speaker Memorial Service	South Ball Room
1:00 p.m.-2:00 p.m.	Luncheon	Arcade
SATURDAY, APRIL 21		
8:30 a.m.-12:00 Noon	Registration and Information	Foyer
8:30 a.m.-12:00 Noon	Hospitality and Exhibits	Foyer
8:00 a.m.-10:15 a.m.	Past Presidents' Breakfast	17-18 Room
9:00 a.m.-10:15 a.m.	Second General Session Awards Installation of Officers	South Ballroom
10:15 a.m.-10:30 a.m.	Post-Convention Executive Board Meeting Awards	South Ballroom
6:30 p.m.-7:30 p.m.	MAG President's Reception and Banquet	

MEDICAL ASSOCIATION OF GEORGIA 125th ANNUAL SESSION

April 20, 21, 22, 1979

Savannah, Georgia

HOTEL RESERVATION INFORMATION

1. The De Soto Hilton has been designated as the Headquarters Hotel. Association officers, directors, and delegates will receive special housing forms for making their reservations at the De Soto-Hilton.
2. The De Soto Hilton is the Headquarters for the Auxiliary to MAG.
3. Assignment of rooms will be made in the order of receipt by the hotel of choice. Please indicate a second choice so that the hotel of the first choice can forward the reservation, should they be completely booked.
4. Make your reservations early. Unreserved room blocks will be released on March 29, 1979.
5. DEPOSIT REQUIRED TO CONFIRM RESERVATIONS.

HOTEL DAILY ROOM RATES

(European Plan—Meals Not Included)

DE SOTO HILTON:	15 E. Liberty St., Savannah, GA 31401 $38 Single; $51 Double
DOWNTOWNER:	201 W. Oglethorpe Ave., Savannah, GA 31401 $26 Single; $36 Double
RAMADA INN:	231 W. Boundary St., Savannah, GA 31401 $20 Single; $25 Double

To make your reservations fill out the form on the opposite page and mail it to the hotel of your choice



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MEDICAL ASSOCIATION OF GEORGIA

April 20, 21, 22, 1979

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(HOTEL NAME)

Please reserve the following accommodations in my name for arrival:

_____, at _____ a.m. p.m., and departure _____ a.m. p.m.
(date) (time) (date)

Type of accommodation _____ for _____ # persons.

List additional occupants:

_____ _____

_____ _____

_____ _____

Please mail a confirmation of these reservations to:

Name _____

Address _____

Enclose deposit of one night's lodging plus
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(Addresses are on opposite page)

Address of the President of the American Medical Association

The Question Is . . .

TOM E. NESBITT, M.D.*

I FLEW INTO CHICAGO last Tuesday with my mid-year message to this House of Delegates well in hand. But less than 24 hours later, the ruling against the American Medical Association (AMA) by a Federal Trade Commission (FTC) judge was made public. To reiterate, the substance of this ruling is that the Association, as well as the Connecticut State Medical Society and the New Haven County Medical Association, have restrained physician advertising, and restrained physician participation in other health care delivery systems. Furthermore, this ruling — if approved by the FTC — would prohibit the AMA from establishing ethical guidelines in certain areas without first securing permission from the FTC; cast the AMA in the role of federal informer for any possible violations of the ruling by state or county medical societies; and compel the AMA to become a policeman for the FTC in enforcing provisions of the ruling.

What, then, is the response of your elected leadership to this ruling? Well, now hear this solemn promise: We intend to employ every weapon at our command, legal or legislative, to fight this ruling. If necessary, we'll take our case to the Supreme Court. We intend to fight because the AMA is a private, voluntary association, and not an involuntary extension of the FTC. We intend to fight because state and local medical societies are free and independent organizations over which the AMA has not, does not, and should not, have authority. We intend to fight because of the timeless and irrevocable oath that all reputable physicians observe, the oath that says, first, we must do no harm — such as the injury and death that have resulted from the unscrupulous public solicitation of patients for some abortion mills here in Chicago; as well as from the misleading solicitation of patients for cosmetic surgery in California, Florida, and elsewhere. We intend to fight because it is false and misleading advertising, and not straightforward advertising by reputable physicians, that the AMA opposes. As recently as last June [1978], when this House met in St. Louis, our Association supported continued experimentation with alternate mechanisms for the delivery of medical care.

If medicine must accept the federal government as the final arbiter of the ethical conduct of the profession and its practitioners, what about other professions and institutions in our society, such as the news media, charitable organizations, and perhaps even state and local governments and their agencies? Should the federal government be the final judge for the ethical conduct of just about every citizen? I think there are three answers to that question. NO! NO! And NO!

"We intend to fight because the AMA is a private, voluntary association, and not an involuntary extension of the FTC."

There is a larger and more critical question now before this House of Delegates — one which must be answered before we adjourn on Wednesday. We intend to fight the ruling by the FTC judge tooth and nail. But the question is: Will we be able to?

We may not be able to do so, you see, especially if we ourselves become our own worst enemies by risking professional suicide over the issue of chiropractic. Now make no mistake about it. If we do become hopelessly divided over the chiropractic dispute, if we do leave this Winter Meeting in dangerous disarray, then it will be tantamount to professional suicide. Even worse, it would be a needless sacrifice. Because when you strip the chiropractic dispute of its emotional overtones, you find that the AMA's basic position that chiropractic is an unscientific discipline is not at issue in the Pennsylvania and New Jersey litigation. This position is at issue in the Chicago litigation, which is where we will take our legal stand; that chiropractors, as individuals, are licensed in all 50 states. The agreed-upon settlement in the Pennsylvania case simply states that "specialists, including those in radiology or clinical pathology, ethically may choose either to accept or to decline patients sent to them" by chiropractors. This conforms to our Principles of Medical Ethics which specify that "a physician may choose whom he will serve."

But this freedom of choice would be conspiracy if we collectively agreed to make the same choice, which is what the specialty societies involved would

* Delivered at the Interim Meeting in Chicago on December 3, 1978.

have us do in Pennsylvania and New Jersey. This would clearly be illegal. Worse yet, the penalties exacted would result in a crippling blow to everything that the AMA is, and means, to American medicine.

Consider our continuing contributions to the preeminence of our medical schools, and the excellence of our graduate and specialty training programs. The beneficial fruits of these commitments are not hard to find. In just 5 years, between 1971 and 1976, the number of accredited medical schools increased from 103 to 116, the number of medical graduates from 9,000 to more than 13,000, and the total number of physicians increased from 359,000 to 425,000.

"If we do become hopelessly divided over the chiropractic dispute . . . then it will be tantamount to professional suicide."

In the coming year we want to maintain the AMA's commitments to the superb quality of American medical education and practice. The question is: Will we be able to? What about the significant and heartening progress we have made within the past year in coping with the problem that tops everyone's medical care hit list — rising medical costs. The evidence of that progress is not hard to find. Acting in concert with the American Hospital Association and the Federation of American Hospitals, we not only met, but surpassed, the basic goal of the Voluntary Effort.

This goal, of course, is to reduce the rate of increase in hospital expenditures by 2 percentage points a year. And, by August 1, this rate of increase had been reduced by 3 percentage points, down to about 13%, as compared with the 1977 increase of about 16%. We achieved this success because thousands of individual health professionals across the country voluntarily joined us in the Voluntary Effort. Within the past year alone, more than 40% of the nation's 7,000-plus hospitals have been certified as cost-containment institutions. More than 45 states have established provisional cost-containment certification programs, while at least eight states have adopted their own numerical goals to reduce medical costs.

Meanwhile, within the past few months, a number of medical organizations — including state and local medical societies — have endorsed the Voluntary Effort, and in some cases, my own request that individual physicians voluntarily restrain annual increases in their own professional fees. To cite some examples, endorsements by state medical societies include those from New Jersey, Virginia, Kentucky, Missouri, Colorado, Utah, and Washington State. Support [has also come] from various medical schools and specialty societies, as well as housestaff physicians and medical students.

In addition, your AMA officers carried the message for responsive but responsible solutions to today's medical problems — notably cost problems — far and wide. We carried the message to millions of Americans, through the recent advertising campaign that focused partly on what the public itself can do to reduce medical costs. We carried the message to 30 leading newspapers, in face-to-face discussions with editorial representatives, as well as to three major news magazines and several nationally-syndicated columnists. And we carried the message to the top executive teams on 37 of America's largest corporations. Following one such visit, I received a letter from the president of a large corporation, a letter which serves as an unsolicited testament to the effectiveness of our Media and Corporate Visitation Programs. The letter says, in part, "Your rounds of meetings with the national press, corporations, labor, and government representatives clearly show that the AMA is communicating in a way that it has never done before." We also recognize, of course, that physicians, as keepers of the medical gates, have a particularly heavy responsibility in the quest to moderate costs. Hence we have attempted to provide individual physicians with the tools necessary to the task.

"In the coming year we want to maintain the AMA's commitments to the superb quality of American medical education and practice. The question is: Will we be able to?"

We have made available existing tools, such as the AMA cost-containment checklist for individual physicians, appropriate materials from the AMA cost-containment kit distributed to state and local medical societies, and similar materials provided by state and local medical societies themselves. We also are fashioning new tools, such as the collection of precise data on cost containment, so that we can more precisely measure economies we know have been achieved by individual physicians and by our collective voluntary efforts. I should add that this will include any additional efforts directed by this House of Delegates in the wake of the 48 recommendations of the National Commission on the Cost of Medical Care.

During the coming year, we hope to continue our communication and our commitments in voluntary

cost containment. We hope to persuade individual physicians to look hard at their own offices, at their own clinics, and at their own hospitals. We want to remind them that even the smallest economies, when multiplied manyfold, will add up to millions — and ultimately billions — of dollars in savings. We want to remind them they are being asked to do no less than what physicians have always done, which is to affirm the public's abiding faith in us. Such are the cost-containment goals we hope to meet in the coming year. The question is: Will we be able to?

"We achieved this success because thousands of individual health professionals across the country voluntarily joined us in the Voluntary Effort."

Finally, there is the abundant evidence of the AMA's success in helping to ward off potentially-damaging federal legislation during the last session of the Congress. Not enacted was the Califano and Company proposal to slap an arbitrary 9% ceiling on the annual expenditure increases for all hospitals, thereby punishing the efficient along with the inefficient. Not enacted was the Drug Regulation and Reform Bill, which would have further confounded the development, distribution, and use of beneficial new drugs. Not enacted was the proposal to federally license and regulate clinical laboratories intra-state, a proposal we objected to primarily because it would have extended into the laboratories in many physicians' offices. And not enacted were amendments to the 1974 Health Planning Act, including those that would have injected Certificate of Need provisions into physicians' offices.

Now it's obvious to me, as I think it is to you, that the legislative measures I have mentioned, plus numerous others that I haven't mentioned, are almost sure to reappear in the new Congress. Certainly the meat-axe approach to hospital cost containment — ala Califano — is sure to reappear. As are various proposals for national health insurance. And the upcoming NHI debate poses another question for us. Will the AMA continue to be up front with the American people, with an NHI proposal of our own (a proposal which, in actuality, intent and purpose, is a "health insurance improvement plan"?) or will be reduced to the role of a mere NHI critic — and a backseat critic at that?

As a former Delegate to and Speaker of this House, I am fully confident that your answers to the questions I have posed will be the right answers. As a physician, too, I believe your answers will be the right ones. Because the faith that patients have in us as physicians, and the faith that the public has in our profession and in this federation, will be worth exactly nothing unless we demonstrate — conclusively demonstrate — that we have faith in ourselves.

Sixth Annual Pulmonary Symposium

The Sixth Annual **Pulmonary Symposium** will be held at Callaway Gardens on March 9-11, 1979. This symposium is endorsed by the Georgia Thoracic Society. Featured speakers will be **Neil S. Cherniack, M.D.,** Professor of Medicine, Case Western Reserve University, Cleveland, Ohio; **John Hedley-Whyte, M.D.,** Professor of Anesthesia and Respiratory Therapy, Harvard University; and **Arnold Sladen, M.D.,** Professor of Clinical Anesthesiology, Director Surgical Intensive Care Unit, Montefiore Hospital, Pittsburgh. For further information, contact Alan S. Peiken, M.D., Medical Director, Pulmonary Symposium VI, Georgia Lung Association, 2210 Wynnton Rd., Suite 206, Columbus, GA 31906. (Phone 1-404-322-1905.)

Art Buchwald to Speak at 14th Annual Cobb County Symposium

The Cobb County Medical Society, in cooperation with Kennesaw College, the Cobb County Pharmaceutical Association, the Auxiliary to the Cobb County Medical Society, the Cobb County Dental Association, and the Cobb County Bar Association will present its 14th Annual Cobb County Symposium on April 5-6, 1979, with the topic "Can We Afford the Future?" Mr. Art Buchwald, noted humorist, author, and columnist, will give the closing keynote dinner address at the Atlanta Marriott Hotel on Friday night, April 6. Other speakers on the program include Dr. Hazel Henderson, an economist, author and Co-Director of Princeton Center for Alternative Futures, Inc., and Dr. John H. Bryant, Director of the Office of International Health. Also appearing on the program will be a theologian and a lawyer. For information regarding the Cobb County Symposium '79, please contact Symposium '79, Office of Community Services at Kennesaw College, Marietta, GA 30061 or call (404) 422-8770.

Report on Litigation to the House of Delegates, American Medical Association

NEWTON N. MINOW, *Chicago**

Delegates, Officers, and Guests of the American Medical Association —

I am honored to be here today at the invitation of Dr. Hunter and Dr. Rial and to report to you on the status of the litigation in which the American Medical Association is a party. I will describe briefly the legal actions in which the Association is involved and explain the reasoning behind the positions that the Association is taking in each case.

Our firm, Sidley & Austin, was first retained by the AMA in 1974. Since that time, we have been carrying out the Association's determined effort to maintain individual freedom and independence in the practice of medicine as a learned and noble profession. The first case in which we represented the Association, for example, raised the question of whether the Department of Health, Education, and Welfare (HEW) could lawfully promulgate regulations which unduly interfered with the exercise of physicians' professional judgments regarding the hospitalization of patients. As many of you will recall, we succeeded in having those regulations struck down by a Federal District Court which was affirmed by a Court of Appeals. You will be interested to know that in June of this year, the government published an announcement in the Federal Register finally conceding that these regulations were unlawful.

"The Federal Trade Commission launched its own investigation of alleged efforts by the AMA to restrict the number of physicians graduating from medical schools."

We live in a time of increasing governmental intervention in the delivery of medical care. Your Association has, therefore, increasingly taken to the courts to limit bureaucratic interference with the practice of medicine and governmental disregard for the rights of patients and the physicians who serve them. The AMA's efforts in this area have continued during the past year.

Last spring, the Secretary of HEW announced his intention to publish a list of all physicians who treated Medicare beneficiaries in 1977 and to attribute to each physician the amount of income that he or she allegedly had received in Medicare payments. The only justification that the Secretary has offered for this invasion of privacy is that publication of this information might stimulate debate on the costs of health care. Representatives of this Association pointed out to Secretary Califano that this goal could be achieved equally well — but without interfering with anyone's privacy — by not identifying individual physicians or simply by breaking down expenditures by medical procedure rather than by provider. Yet the Secretary refused to compromise.

"Your Association is also resisting efforts by the FTC to remove it from the process of accreditation of medical schools."

Consequently, your Association took the matter last June to Federal Court in Chicago. We were successful in obtaining a court order preventing the proposed publication of the information. At the suggestion of the judge, we then intervened in a pre-existing case in Jacksonville, Florida, in which another court had granted a similar request in a suit previously filed by the Florida Medical Association. This fall the United States District Court in Jacksonville issued a writ of injunction restraining publication of any of the information on the proposed list. Despite the determined efforts of the government to have this injunction lifted, I can report to you that the HEW is still enjoined from publishing the list. A battle on this issue lies ahead, and I assure you that

* Mr. Minow is from the law firm of Sidley and Austin which has acted in an advisory capacity to the AMA in the litigation he describes. This address was delivered at the Interim Meeting in Chicago on December 3, 1978.

we will continue to make every effort to see that it is never published.

At just about the same time that HEW indicated that it would publish the list of the Medicare-related incomes of identified physicians, the Federal Trade Commission (FTC) promulgated a Trade Regulation Rule entitled "Advertising of Ophthalmic Goods and Services." Among other things, this Rule would invalidate all state laws governing the advertising and dispensing of ophthalmic goods and services which the Commission deems unfair. The Rule has direct and immediate ramifications for ophthalmologists. Of great significance, the Rule would, if upheld by the courts, establish the astonishing authority of the FTC to override the laws and policy decisions of state legislatures in medical matters whenever the Commission considers these decisions unfair. It could serve as a precedent which might lead the Commission to try to strike down other state laws such as those regulating medical licensure, medical discipline, and medical practice. Thus, the Ophthalmic Goods Rule poses a threat to the practice of medicine which far transcends its immediate terms.

Your Association has therefore challenged the FTC by turning to the courts. Along with nine sovereign states and the American Optometric Association, we sought review of the Ophthalmic Goods Rule in the United States Court of Appeals in Washington. Our brief was filed in October, and the states filed theirs in November. The brief of the Commission is due this month. If the Court adheres to its customary time schedule, the case will be heard in late spring, and a decision will follow sometime late in 1979 or 1980. I think it likely that this case will ultimately reach the Supreme Court.

"In 1975, the FTC issued, without any prior notice or investigation, a complaint challenging the ethical principles applicable to advertising and solicitation by physicians."

Your Association is also resisting efforts by the FTC to remove it from the process of accreditation of medical schools. In an unprecedented move, the Commission appeared before the United States Office of Education last year to urge that the Liaison Commission on Medical Education (LCME) not be recertified as the official accrediting agency for medical education. It argued that because some of the members of the LCME were appointed by the AMA, the LCME could not be counted upon to make impartial decisions on matters of accreditation. The notion that a professional association should not be involved in such matters is of course reprehensible. The AMA was founded to improve the quality of medical education and has worked continuously for over a century to effectuate this goal. Accordingly, both your Association and the LCME strongly opposed the position that the FTC took before the Office of Education. After a hearing and a review of past performance, the LCME was provisionally recertified for 2 years as the officially recognized accrediting agency for medical schools. That battle will again be fought next year.

Undaunted, the FTC launched its own investigation of alleged efforts by the AMA to restrict the number of physicians graduating from medical school. That investigation has now been pending for over a year. A formal complaint has not as yet been issued. Interestingly, the Commission's staff person with primary responsibility for health matters recently was quoted in the press as saying that the AMA may not have restricted entry into medical schools after all. The facts may be getting through.

"The Administrative Law Judge assigned to the case [regarding advertising and solicitation by physicians] had been for many years a prosecutor for the Commission."

In another area, the facts have not been getting through. I turn now to the attack brought by the FTC on the Association's ethical standards. In 1975, the FTC issued, without any prior notice or investigation, a complaint challenging the ethical principles applicable to advertising and solicitation by physicians. The FTC also attacked the ethical guidelines applicable to a variety of contractual arrangements entered into by physicians — for example, the ethics of a partnership between a physician and a lay person.

When this proceeding was instituted in December of 1975, we attempted to settle the case. We hoped to settle for two reasons. First, we knew that it would be difficult to find a less favorable forum for resolution of the issues raised by the case than the FTC. We feared that we would not get a fair, unbiased proceeding because the Commission had already displayed its hostility to organized medicine. Furthermore, the Administrative Law Judge assigned to the case had been for many years a prosecutor for the Commission. Finally, we knew that, incredible as it might seem to a non-lawyer, we would have to appeal the initial decision of the Administrative Law Judge to the full FTC — the very people who directed the complaint in the first instance.

Indeed, just last month, all four members of a panel reporting to the National Commission for the Review of Antitrust Laws and Procedures recom-

mended that the FTC's antitrust litigation responsibilities be terminated or significantly modified. As panel member Professor Glen Weston of George Washington Law School observed, the majority of Administrative Law Judges have served as FTC prosecuting lawyers. Moreover, there is also the problem that three of the five commissioners had no significant training in antitrust law before their appointments.

"The Commission insisted that the AMA and state and local medical societies should play absolutely *no role* in setting standards of ethical promotional practices by their members."

Our second reason for seeking to settle was that since the case would involve the production of thousands of documents and scores of witnesses from around the country, we knew that it would be exceedingly costly. The investigation of each document and the preparation of each witness is a difficult, time-consuming, and costly task. So we hoped to be able to save the Association the enormous expense that the case would inevitably entail.

But the staff of the Commission flatly rejected our position that professional associations, including the AMA, have not only the right but the responsibility and duty to see that advertising by their members is limited to truthful, objective, verifiable information that will help enable patients to make an informed choice among physicians. Instead, the Commission insisted that the AMA and state and local medical societies should play absolutely *no role* in setting standards of ethical promotional practices by their members. The staff insisted that advertising by physicians should be regulated exclusively by the government. This was a position that neither you nor we could accept. For it is premised on the proposition that professional men and women cannot be trusted

"The staff insisted that advertising by physicians should be regulated exclusively by the government."

to regulate themselves in the public interest. And that proposition is fundamentally inconsistent with the Association's basic principles.

The decision of the Administrative Law Judge was announced this week. After reading it, I submit that George Orwell's 1984 has arrived 6 years early. The world of Big Brother, seeking to take over the independent, professional practice of medicine, has arrived in 1978.

I wish there were time to undertake an extensive legal analysis of the decision. I will limit this to a summary of our arguments and the manner in which they were resolved.

First, the FTC has jurisdiction only over persons, partnerships, and for-profit corporations. Since the AMA is clearly not a person or a partnership, the question is whether it is organized for the profit of itself or its members. We demonstrated that the vast majority of the Association's activity is devoted to scientific, educational, and public health matters. The judge, however, chose to discount this evidence and to find that the AMA is organized for the profit of its members because it has done such things as offer its members a retirement plan and oppose enactment of certain forms of national health insurance.

Second, we argued that the AMA should be judged on its current ethical positions, not on the basis of statements from the 1930s, 40s, 50s and 60s made in a vastly different legal and social climate. The judge absolutely refused to accept this argument and virtually ignored the 1977 edition of the *Opinions and Reports of the Judicial Council*.

"The FTC has jurisdiction only over persons, partnerships, and for profit corporations. Since the AMA is clearly not a person or a partnership, the question is whether it is organized for the profit of itself or its members."

We pointed out that questions of ethics are local matters which arise locally and are resolved locally. We demonstrated that state and local medical societies are autonomous organizations which make decisions independently of the AMA. Apparently ignoring this evidence, the judge found that there is a grand conspiracy among the AMA and state and local medical societies to stifle all advertising and subvert any innovative form of health care delivery.

I could go on and on and on, but the Opinion is 312 pages, single-spaced. The one positive note is that this order is not a final one. It still must go before the full FTC, the United States Court of Appeals, and possibly the Supreme Court before it becomes final. While we are not optimistic about the results before the FTC, we are hopeful that we shall find justice when we have our day in the federal courts. We will not rest until this misguided decision — so contrary to the public interest and so alien to our basic American traditions of freedom — is overturned.

I say that because I believe that the Initial Decision of the Administrative Law Judge is a direct assault on the entire concept of professionalism and will, if allowed to stand, lead to the deception and injury of thousands upon thousands of innocent patients.

The order entered by the Administrative Law Judge would forbid the AMA and its constituent and component medical societies from involving themselves in any way in the advertising, promotional practices, or contractual arrangements of physicians. Thus, if an AMA member were to make misleading claims about his or her skill or fees, the medical societies would be powerless even to advise the physician of the problem or to declare the advertising unethical. All that they could do would be to complain to Big Brother — in the form of the FTC.

"The Judge . . . [found] that the AMA is organized for the profit of its members because it has done such things as offer its members a retirement plan and oppose enactment of certain forms of national health insurance."

It must be asked: How could this Administrative Law Judge have reached these results? The short answer is that he distorted or ignored much of the evidence and most of the applicable law.

In our defense of the case, we offered witnesses who had literally been mutilated after responding to misleading advertisements and high pressure tactics of certain advertising physicians. We have testimony from the mother of a woman who died as a result of an abdominoplasty performed by an advertising physician after several other physicians had advised the patient that she was an unacceptable risk for surgery. On the witness stand, these patients begged medical societies to do something to prevent the fraud and incompetence to which they had fallen victim. Now an FTC employee has said that the medical profession is prohibited by law from doing anything to regulate this kind of behavior. And it is equally forbidden to take any action against those within its ranks who advertise the worst sort of abortion mills, who claim that they will guarantee a weight loss of 20 pounds within 2 weeks, and who make other statements which lead patients to choose physicians on the basis of who is the best advertiser rather than who is the best physician.

As outrageous as this is, there is another aspect of the Administrative Law Judge's order which is even more sweeping. And that is this: The AMA may not even establish ethical guidelines governing the advertising and solicitation practices of its members unless it first obtains "the permission and approval of the Federal Trade Commission." This provision has staggering implications for the First Amendment, the traditions of professionalism, and ethical standards which have always been basic values in our society. This provision would mean that federal officials in Washington, and not the profession itself, would determine what constitutes ethical behavior by physicians.

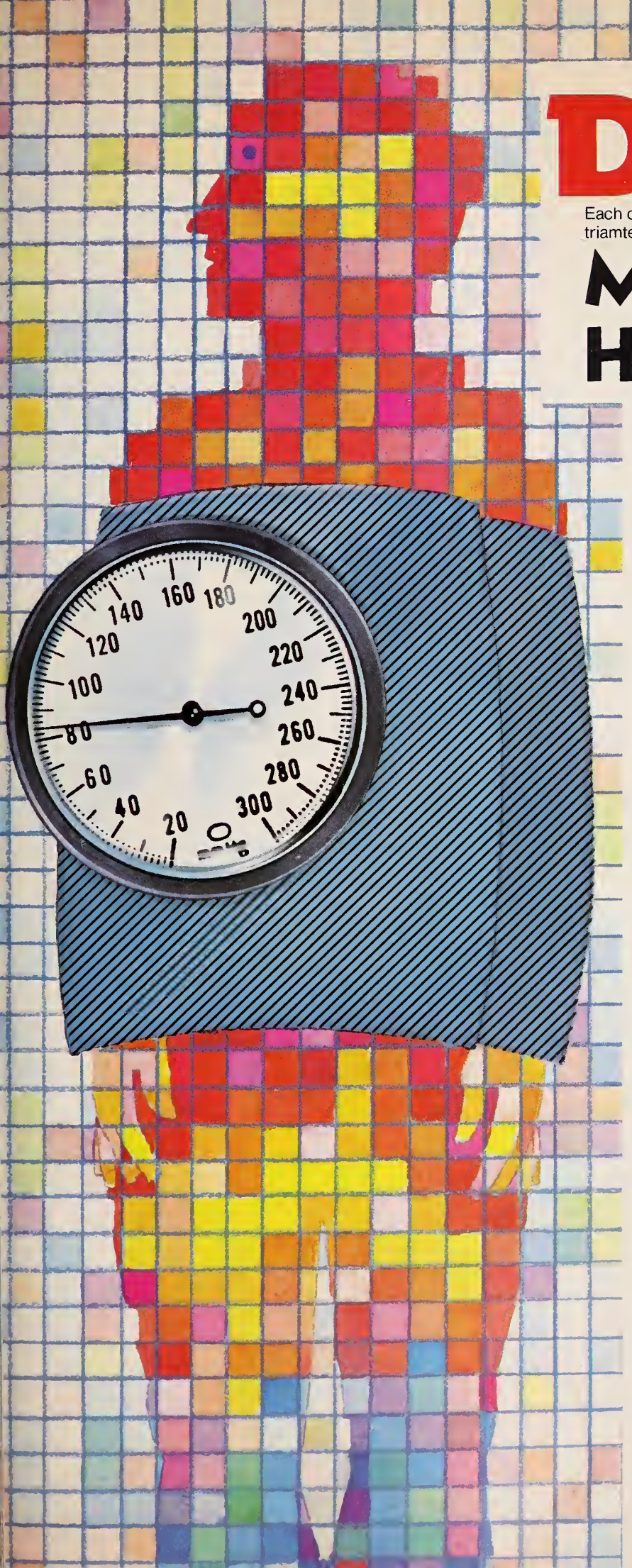
I am reminded of the poem "The Second Coming" by William Butler Yeats. In that poem, Yeats said, "The best lack all conviction/While the worst are full of passionate intensity." In its misguided zeal, the FTC has been full of passionate intensity. But we as professionals must never lose the courage of our convictions. We will do everything we can to seek reversal of this attempt to put the independent practice of medicine in the hands of government.

In the cases discussed thus far, our adversary has been an agency of the federal government. I turn now to another set of cases in which the Association is involved. Here, our opponent is not the government but a number of individual chiropractors. These chiropractors have brought actions against the AMA and several other defendants in three different forums — federal court in Philadelphia, state court in New Jersey, and federal court in Chicago.

All three of these actions have several features in common. Each is brought under antitrust laws which declare it unlawful for two or more persons to combine or conspire to restrain competition. Plaintiffs in each case contend that by declaring it unethical to associate professionally with unscientific practitioners, physicians have combined to prevent chiropractors from competing within the limits of their licenses. More specifically, plaintiffs in each case take the position that physicians have conspired to restrain competition by uniformly denying chiropractors access to the use of diagnostic procedures that they require in order to practice within the scope of their license.

"The order entered by the Administrative Law Judge would forbid the AMA and its constituent and component medical societies from involving themselves in any way in the advertising, promotional practices, or contractual arrangements of physicians."

At the same time, the three actions differ from one another in some respects. The Pennsylvania and New Jersey cases are each brought by local chiropractors concerned with local conditions. The



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* **Warning**
This drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual. If this combination represents the dosage so determined, its use may be more convenient in patient management. Treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

Contraindications: Further use in anuria, progressive renal or hepatic dysfunction, hyperkalemia. Pre-existing elevated serum potassium. Hypersensitivity to either component or other sulfonamide-derived drugs.

Warnings: Do not use potassium supplements, dietary or otherwise, unless hypokalemia develops or dietary intake of potassium is markedly impaired. If supplementary potassium is needed, potassium tablets should not be used. Hyperkalemia can occur, and has been associated with cardiac irregularities. It is more likely in the severely ill, with urine volume less than one liter/day, the elderly and diabetics with suspected or confirmed renal insufficiency. Periodically, serum K+ levels should be determined. If hyperkalemia develops, substitute a thiazide alone, restrict K+ intake. **Associated widened QRS complex or arrhythmia requires prompt additional therapy.** Thiazides cross the placental barrier and appear in cord blood. Use in pregnancy requires weighing anticipated benefits against possible hazards, including fetal or neonatal jaundice, thrombocytopenia, other adverse reactions seen in adults. Thiazides appear and triamterene may appear in breast milk. If their use is essential, the patient should stop nursing. Adequate information on use in children is not available.

Precautions: Do periodic serum electrolyte determinations (particularly important in patients vomiting excessively or receiving parenteral fluids). Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics or those with suspected or confirmed renal insufficiency. Watch for signs of impending coma in severe liver disease. If spironolactone is used concomitantly, determine serum K+ frequently; both can cause K+ retention and elevated serum K+. Two deaths have been reported with such concomitant therapy (in one, recommended dosage was exceeded, in the other serum electrolytes were not properly monitored). Observe regularly for possible blood dyscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving triamterene, and leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with thiazides. Triamterene is a weak folic acid antagonist. Do periodic blood studies in cirrhotics with splenomegaly. Antihypertensive effect may be enhanced in post-sympathectomy patients. Use cautiously in surgical patients. The following may occur: transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), hyperuricemia and gout, digitalis intoxication (in hypokalemia), decreasing alkali reserve with possible metabolic acidosis. 'Dyazide' interferes with fluorescent measurement of quinidine.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis, rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting, diarrhea, constipation, other gastrointestinal disturbances. Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and, rarely, allergic pneumonitis have occurred with thiazides alone.

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Demonstrated smooth muscle relaxant activity.

In this double-blind study, twenty patients having G.I. series and exhibiting spasm were randomly selected to receive either 2 cc. of Bentyl or sodium chloride intramuscularly. Ten minutes after the injection another radiograph was taken . . .

. . . Bentyl produced definite relaxation in 8 of 10 patients. The sodium chloride produced relaxation in only 3 of 10. No side effects occurred in either group of patients.



Pylorospasm has almost totally blocked passage of barium meal.



Barium meal beginning to pass 10 minutes after intramuscular injection of 20 mg. Bentyl.

"The correlation of spasm relief and drug given was excellent."

*This drug has been classified "probably" effective in treating certain functional G.I. disorders.

†See Warnings, Precautions and Adverse Reactions.

See following page for prescribing information.

Reference:
King, J.C. and Starkman, N.M.: Evaluation of an antispasmodic. Double-blind evaluation to control gastrointestinal spasms occurring during radiographic examination. A preliminary report. Western Med. 5:356-358, 1964.

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IT SHOULD BE NOTED AT THIS POINT IN TIME THAT THERE IS A LACK OF CONCURRENCE AS TO THE VALUE DF ANTICHOLINERGICS/ANTISPASMOOICS IN THE TREATMENT OF GASTRIC ULCER. IT HAS NOT BEEN SHDWN CONCLUSIVELY WHETHER ANTICHOLINERGIC/ANTISPASMDDIC DRUGS AIO IN THE HEALING OF A PEPTIC ULCER, OECREASE THE RATE OF RECURRENCES, DR PREVENT COMPLICATION

Based on a review of this drug by the National Academy of Sciences–National Research Council and/or other information, FDA has classified the following indications as "probably" effective:

May also be useful in the irritable bowel syndrome (irritable colon, spastic colon, mucous colitis, acute enterocolitis, and functional gastrointestinal disorders); and in neurogenic bowel disturbances (including the splenic flexure syndrome and neurogenic colon).

THESE FUNCTIONAL DISORDERS ARE OFTEN RELIEVED BY VARYING COMBINATIONS OF SEDATIVE, REASSURANCE, PHYSICIAN INTEREST, AMELIORATION OF ENVIRONMENTAL FACTORS.

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Final classification of the less-than-effective indications requires further investigation.

CONTRAINOICATIONS: Obstructive uropathy (for example, bladder neck obstruction due to prostatic hypertrophy); obstructive disease of the gastrointestinal tract (as in achalasia, pyloroduodenal stenosis); paralytic ileus, intestinal atony of the elderly or debilitated patient; unstable cardiovascular status in acute hemorrhage, severe ulcerative colitis; toxic megacolon complicating ulcerative colitis; myasthenia gravis. WARNINGS: In the presence of a high environmental temperature, heat prostration can occur with drug use (fever and heat stroke due to decreased sweating). Diarrhea may be an early symptom of incomplete intestinal obstruction, especially in patients with ileostomy or colostomy. In this instance treatment with this drug would be inappropriate and possibly harmful. Bentyl may produce drowsiness or blurred vision. In this event, the patient should be warned not to engage in activities requiring mental alertness such as operating a motor vehicle or other machinery or perform hazardous work while taking this drug. PRECAUTIONS: Although studies have failed to demonstrate adverse effects of dicyclomine hydrochloride in glaucoma or in patients with prostatic hypertrophy, it should be prescribed with caution in patients known to have or suspected of having glaucoma or prostatic hypertrophy. Use with caution in patients with: autonomic neuropathy; hepatic or renal disease; ulcerative colitis–Large doses may suppress intestinal motility to the point of producing a paralytic ileus and the use of this drug may precipitate or aggravate the serious complication of toxic megacolon; hyperthyroidism, coronary heart disease, congestive heart failure, cardiac arrhythmias, and hypertension; hiatal hernia associated with reflux esophagitis since anticholinergic drugs may aggravate this condition.

It should be noted that the use of anticholinergic/antispasmodic drugs in the treatment of gastric ulcer may produce a delay in gastric emptying time and may complicate such therapy (antral stasis). Do not rely on the use of the drug in the presence of complication of biliary tract disease. Investigate any tachycardia before giving anticholinergic (atropine-like) drugs since they may increase the heart rate. With overdosage, a curare-like action may occur. ADVERSE REACTIONS: Anticholinergics/antispasmodics produce certain effects which may be physiologic or toxic depending upon the individual patient's response. The physician must delineate these. Adverse reactions may include xerostomia; urinary hesitancy and retention; blurred vision and tachycardia; palpitations; mydriasis; cycloplegia; increased ocular tension; loss of taste; headache; nervousness; drowsiness; weakness; dizziness; insomnia; nausea; vomiting; impotence; suppression of lactation; constipation; bloated feeling; severe allergic reaction or drug idiosyncrasies including anaphylaxis; urticaria and other dermal manifestations; some degree of mental confusion and/or excitement, especially in elderly persons; and decreased sweating. With the injectable form there may be a temporary sensation of lightheadedness and occasionally local irritation. DOSAGE AND AOMINISTRATION: Dosage must be adjusted to individual patient's needs.

Usual Dosage: Bentyl 10 mg. capsule and syrup: *Adults*: 1 or 2 capsules or teaspoonfuls syrup three or four times daily. *Children*: 1 capsule or teaspoonful syrup three or four times daily. *Infants* ½ teaspoonful syrup three or four times daily. (May be diluted with equal volume of water.) Bentyl 20 mg.: *Adults*: 1 tablet three or four times daily. Bentyl Injection: *Adults*: 2 ml. (20 mg.) every four to six hours intramuscularly only. NOT FOR INTRAVENOUS USE. MANAGEMENT OF OVERDOSE: The signs and symptoms of overdose are headache, nausea, vomiting, blurred vision, dilated pupils, hot, dry skin, dizziness, dryness of the mouth, difficulty in swallowing, CNS stimulation. Treatment should consist of gastric lavage, emetics, and activated charcoal. Barbiturates may be used either orally or intramuscularly for sedation but they should not be used if Bentyl with Phenobarbital has been ingested. If indicated, parenteral cholinergic agents such as Urecholine® (bethanecol chloride USP) should be used.

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Chicago case, by contrast, is brought by chiropractors from different parts of the United States. They appear to be concerned primarily with the effect of various medical society positions on chiropractic as a whole. Thus, the relief they seek is infinitely more sweeping than that sought by plaintiffs in Pennsylvania and New Jersey. They have asked, for example, for millions of dollars in damages and for 1 million dollars for each of the next 10 years to establish and operate a research institute for the advancement of chiropractic.

Finally, the three cases have this in common: The defense of each lawsuit has required a heavy financial outlay by this Association, which because of its size and public visibility is inevitably viewed as the principal defendant. The expenditure of resources that has occurred until now will be dwarfed by the expenses that will be incurred if the cases go to trial. Moreover, any adverse decision against the AMA in a litigated case will in all likelihood provoke treble-damages lawsuits against the Association and against state and local medical societies by chiropractors throughout the country.

"Chiropractors have brought actions against the AMA and several other defendants in three different forums — federal court in Philadelphia, state court in New Jersey, and federal court in Chicago."

In view of the costs and risks of these lawsuits, we believe that the most responsible course is to explore settlement on reasonable terms — just as we would explore settlement of any case of this nature. In fact, as you know, a tentative settlement agreement has been reached by the Association in the Philadelphia case. Under the terms of this tentative settlement, the AMA acknowledges simply that each individual physician must decide for him or herself whether and in what circumstances to accept referrals from a chiropractor. It acknowledges that chiropractors are licensed limited practitioners as that term is used in the *Opinions and Reports of the Judicial Council*.

The Association is represented by a different local law firm in each of these chiropractic cases. Our firm has acted in an overview advisory capacity to the AMA in these suits. We have carefully reviewed the tentative settlement in light of the applicable law. On the basis of this review, we conclude that this settlement is a reasonable one and is in the best interests of the Association. Our opinion on this matter is shared by the able Philadelphia law firm which represents the Association in this case on a day-to-day basis.

Four specialty societies and some individual physicians, however, disagree with our assessment. Representatives of these societies feel so strongly about this subject that they have taken legal steps to try to prevent finalization of the settlement. While we respect their views, our own independent judgment differs from their opinion.

"I will therefore briefly discuss some of the antitrust implications of the chiropractic litigation."

As we understand it, the position of these specialty societies is based on three concerns. First, the societies believe that an acknowledgement that chiropractors are licensed limited practitioners would give chiropractic legitimacy as a healing art. Second, they fear that settlement of the Philadelphia case would have an adverse effect on the defense of the Chicago case. Third, they contend that the tentative settlement would violate Principle 3 of the Principles of Medical Ethics, which provides that a physician shall not "associate professionally" with anyone who practices a method of healing not founded on a scientific basis. These are very important and deeply felt concerns, all of which deserve respect — and answers.

First, in acknowledging that chiropractors are licensed limited practitioners, the settlement merely recognizes the fact that chiropractors have been licensed under the law of every state to perform certain limited procedures prescribed by state law. Much as we might wish it otherwise, the state legislatures in all 50 states have already considered chiropractors as licensed limited practitioners. The tentative settlement in no way changes the legal status of chiropractors.

Moreover, it is basic to understand that the settlement terms agreed upon by the AMA in no way obligate any physician to have any contact whatsoever with any chiropractor. If an individual physician considers chiropractors to be unscientific

"A tentative settlement agreement has been reached by the Association in the Philadelphia case."

cultists, as far as the AMA is concerned that physician need never accept a referral from a chiropractor. Indeed, anyone who sought to force a physician to treat patients sent by a chiropractor, be it the government, a hospital board, or a group of indi-

viduals, would be acting contrary to the AMA position.

Second, both in our judgment and that of the lawyers representing the Association in Philadelphia and in Chicago, the settlement does not jeopardize the defense of the Chicago case. It does not in any way constitute an admission that the AMA has violated the law. In fact, it makes no statement about legal liability. What it does do is make clear that the AMA's position is that it is up to the individual physician to decide whether or in what circumstances to accept patients sent by chiropractors. If anything, therefore, the settlement helps our defense in Chicago because this position is far easier to defend under the antitrust laws than is a blanket prohibition on accepting referrals in any circumstances. Moreover, the tentative settlement removes the possibility of an adverse ruling in the Philadelphia case. In this connection, we are of the opinion that your Board of Trustees has appropriate authority to settle lawsuits when it believes that settlement is in the best interest of the Association.

Third, the settlement is, in our judgment, consistent with the prohibition in the Principles of Medical Ethics against associating professionally with an unscientific practitioner. The Judicial Council's interpretation of this prohibition declares it unethical for a physician to enter a course of treatment jointly with an unscientific practitioner. It does not interpret the Principles to forbid accepting a referral from such

"From the decision of the FTC Administrative Law Judge: *'Respondents will be permitted to participate in setting ethical guidelines for the conduct of their members after first obtaining permission and approval of the Federal Trade Commission.'*"

an individual and thereafter dealing with the patient exclusively. As I read the Principles as interpreted by the Judicial Council, the tentative settlement is in complete accord with the Association's policy that a physician may accept a referral from an unscientific practitioner as long as the physician doesn't undertake a course of treatment together with such practitioner.

Under ordinary circumstances, a speaker's platform is not the best place for a lawyer to give advice to a client. But the circumstances facing the AMA today are not ordinary. I will therefore briefly discuss some of the antitrust implications of the chiropractic litigation.

Although the Sherman Antitrust Act was enacted in 1890, it was not until *Goldfarb* v. *Virginia State Bar Association, et al.* was decided in 1975 that the Supreme Court first declared that there was no "learned profession" exclusion from application of the Act. As a result, physicians, lawyers — all professionals — are now subject to the Sherman Act. Under this Act and analagous state statutes, a concerted refusal to have anything to do with certain providers of goods or services, under threat of disciplinary action, is a violation of law.

"This Association should not now adopt a position contrary to law and contrary to its own ethics which require that physicians observe the law."

Neither this House nor the Judicial Council has ever stated that a physician may not individually decide to accept as his or her patient a person sent for treatment or diagnosis by a chiropractor. As a matter of fact, if the AMA or any other medical organization threatened to discipline for unethical conduct members who accept patients referred by chiropractors, regardless of circumstance, that organization would be in direct violation of the Sherman Antitrust Act.

Chiropractic as a system of treating *all* disease by spinal manipulation or adjustment was described by the AMA House of Delegates in 1966 as an "unscientific cult" and a "hazard to rational health care." The AMA is clearly within its "first amendment" rights when it continues to express its concern about the danger of unscientific methods of treatment. But it should not take a position which would make it unethical for a member to decide individually to accept as a patient a person referred by a chiropractor.

As you know, Section 4 of the Principles of Medical Ethics requires physicians to "observe all laws." Judicial Council Opinion 3.70 is consistent with the law and reflects the long-standing position of the AMA both prior to the *Goldfarb* decision in 1975 and since. We are unaware of a single instance in which a surgeon has been disciplined by the AMA or any medical society for performing surgery on a patient referred by a chiropractor. Nor are we aware of any radiologist or other physician who has been censored or admonished for accepting for treatment or diagnostic services a patient sent by a chiropractor. This Association should not now adopt a position contrary to law and contrary to its own ethics which require that physicians observe the law.

You are committed to improving people's health through scientific medicine. I share your outrage

when innocent patients are exposed to unscientific practices contrary to their best interests. You who are devoted to the welfare of the patient must be appalled when state legislatures permit a system of treatment which runs directly contrary to this goal. But your concern for the patient and for quality care cannot lead you into positions that violate the law — in this case, the antitrust laws — no matter how well-intentioned those positions are.

* * *

"In 1975, the Supreme Court first declared that there was no 'learned profession' exclusion from application of the [Sherman Antitrust] Act."

In June of 1977, the Chairman of the FTC said: "The Federal Trade Commission is not a health or medical agency. To paraphrase a President who was hardly our patron saint, Calvin Coolidge, 'The business of the FTC is business.' And we recognize, along with most Americans, that the delivery of health care is business, an industry of vast proportions and vital effect. Health Care has become our business. I have no apologies for that; in fact, one might ask: 'What took the FTC this long?'"

As men and women trained in a noble and learned profession, you are now on notice that parts of our government claim that the medical profession is not a profession but a business — and that health care is now the FTC's business. At a time when the President and many members of Congress are saying that our country is over-regulated, the FTC wants to regulate the practice of medicine. I read you one ominous sentence from the decision of the FTC Administrative Law Judge: "*Respondents will be permitted to participate in setting ethical guidelines for the conduct of their members after first obtaining permission and approval of the Federal Trade Commission.*"

1984 has arrived in 1978. You, the members of an ancient and honored profession are not even to participate in setting your own ethical standards without first getting the permission and approval of the federal government. I don't have to tell you how much is at stake here, fundamental principles far beyond this particular case.

I serve in another cause with Dallin H. Oaks, President of Brigham Young University, who is also a leader of the American Association of Independent Colleges and Universities. President Oaks said a few months ago: "I contend that government authorities need to be just as careful about regulating schools, colleges, and universities as they are about interferences with newspapers, public meetings or any other delivery mechanism for the products of free speech. As the essential transmitters of our culture and as the source, teacher, and practitioner of values in our society, schools, colleges, and universities must be assured a wide range of freedom for their activities of discovery, advocacy, and practice."

"It is essential that all of you remain united to preserve your freedom — and the freedom of your patients."

The same observation is true with respect to the practice of medicine. The freedom to practice medicine is at stake, not only for yourselves, but for your patients and for future physicians and future patients. It is essential that all of you remain united to preserve your freedom — and the freedom of your patients. I am proud to carry on the battle to maintain professionalism, for it is a just one.

In accepting the Nobel Prize for literature, William Faulkner declared, "I believe that man will not merely endure: He will prevail." In acting as counsel to this great Association, I share Faulkner's faith. I believe that as long as it stands together, the medical profession will not merely endure. It will prevail.

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president's letter

Morals, Ethics, and Medicine

ALEXANDER SOLZHENITZYN, speaking at Harvard, deplored American materialism. He urged a return to earlier and more beneficent values. Shortly thereafter, the newly inaugurated president of the New York Medical Society said that Solzhenitzyn could have been talking to the medical profession. As H. L. Menchen would have said, they may be right. We need those values, and physicians would do well to aspire to them.

The story of the practice of medicine is a story of self-discipline and of a standard of performance that transcends legal obligations and the structure of mere licensure. There have always been physicians as well as mere members of the medical profession, even as there are lawyers and mere members of the bar. There is no better time than now for a physician to renew his vows and to manage his medical practice with the same high ethical and moral guidelines to which he subscribed when he entered the profession.

Any institution so important to the welfare and well-being of our people can expect to be under fire and an object of criticism. As our role in society expands, the more will we be the object of scrutiny. Trouble invites palliation. Palliation invites criticism. For there is no perfect palliative.

But when the fear of criticism, or of pressure from governments and regulative bureaucracies, or the tirades of vote-seeking politicians is allowed to interfere with the day-to-day proper health care of the patient, then may we know that we are not doing what we should. Those of us who are deeply involved in organized medicine must not allow the cacophony to make us defensive. Paranoia is certainly not an answer.

For the fact is that, on balance, we have (and enjoy) the respect and the admiration of the American people. That being said, we must also say this: we merit the esteem only so long as we meet two criteria. The first is that we seek to achieve for our patients the highest level of medical care. The second is that we continue to show concern and empathy for the individual patient. There will never be a substitute for caring. An honored position in the community mandates responsible actions on the part of him who is honored.

The medical profession must not passively permit others to shape its future. For that reason, you should act affirmatively. Every physician should show a positive attitude, not only in the delivery of health care, but also in all areas that affect the lives of American citizens. In other words, light a candle. For it is true that we should do more than utter a perfunctory tut-tut at the front page, the while turning to the sports page.

One must care and must be concerned with energy, with individual freedom, with government budgets that don't balance, and with governmental inefficiency — as well as with attempts to ration health services, among other things. A responsible member of the medical community should try to be innovative, creative, and practical at the same time. Caring is the key. Implementing that care is the handle.

We do that by rededicating ourselves to a continuous effort to promote the morals, the ethics, and the sound principles that have made our medical profession the finest, the most effective, the most respected in the world.

Sincerely,

Carson B Burgstiner MD

Carson B. Burgstiner, M.D.
President, MAG

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FTC's Advertising Decision — A Lawyer's Perspective

ON NOVEMBER 13, 1978, the Federal Trade Commission's (FTC) Administrative Law Judge Ernest G. Barnes rendered an initial decision in the FTC's complaint against the American Medical Association (AMA) and others. Judge Barnes found that the AMA has restrained competition in the area of providing physician services and has caused substantial public injury as a result of its ban on advertising.

As has already been noted publicly, Judge Barnes is technically an employee of the FTC, which brought the case initially, so it is not surprising that his opinion reflected many of the FTC's allegations. Finally, it has been duly noted that Judge Barnes' decision is an initial decision only, that appeals will be filed to the full FTC, and that appeals beyond that level will also be filed in the event of further adverse ruling on this case. The net result is that unless some settlement of the matter is reached, it may well be 4 or 5 years before Judge Barnes' decision becomes binding on the AMA.

The specific recommendations contained in Judge Barnes' order would require the AMA to cease and desist from a number of challenged activities:

1. Interfering with advertising or publishing by any person of the prices, terms, or conditions of sale of physician services or of information about physician services, facilities, or equipment offered for sale by physicians.
2. Interfering with the solicitation of patients, patrons, or contracts to supply services.
3. Interfering with the commercial terms or conditions on which any physician contracts or seeks to contract for the sale, purchase, or distribution of his services.
4. Interfering with the growth or operation of any prepaid health plan by means of statements regarding the ethical propriety of those plans.
5. Urging any physician, group of physicians, hospital, insurance carrier, etc., to take any of the above actions.

The order, however, is careful to preserve the rights of the AMA, its component societies or any members, to make good faith reports to governmental agencies regarding any violations of law in the form of (a) instances of false or deceptive advertising or solicitation, or (b) instances of uninvited in-person solicitation of those patients who are vulnerable to harassment or duress. In addition, the order would permit the AMA, after a 2-year period, to formulate ethical guidelines governing advertising and solicitation of patients — so long as the AMA would first obtain approval of those guidelines from the FTC.

The FTC proceedings contained a number of peripheral issues which lawyers and administrative scholars will debate vigorously: Is the AMA a "profit-making" corporation sufficient to give the FTC jurisdiction in the matter? (Judge Barnes held

that the FTC had jurisdiction.) Is the AMA to be judged by its current policies on advertising and solicitation or on its own policies which were formulated 10, 20, or 30 years ago? (Judge Barnes ignored the newly stated AMA policy on advertising and solicitation.) Is the AMA responsible for the actions of state and local societies which make up its membership? (Judge Barnes held that the AMA was responsible in this instance.)

Although any of these peripheral issues could become a controlling issue in the case, if Judge Barnes is reversed on appeal, none of these issues have the scope and magnitude of the broader economic issue which is central not only to this case, but also to many other current debates in the health care field: What is the proper balance between governmental regulation and competitive market forces in effecting a pricing mechanism health care?

Historically, competitive market forces have played only a minor role in the pricing of health care services. Doctors, like lawyers, were considered members of a ''learned profession'' where the services rendered were of such an esoteric quality that the public could not possibly be given enough accurate information from which to make informed economic decisions among competitors. Because of perceived risks of public injury through false or deceptive advertising by members of ''learned professions,'' a tradition developed prohibiting all forms of advertising or solicitation by those professions. The same notion expanded into a general exemption (the ''learned profession'' exemption) from the application of antitrust principles, since those rules were designed to encourage the effectiveness of competitive market pricing mechanisms. Practices therefore developed in the health care field which would have been clearly prohibited or highly questionable in other businesses: doctors have been prohibited from increasing competitive forces by means of advertising; doctors themselves have been permitted to make decisions affecting the accreditation of medical schools, as well as decisions regarding licensure, hospital staff privileges, and review of quality of care, all of which directly affect the number of competitors in the physician services market.

With the recent rapid expansion of health care costs, the traditional pricing mechanism has come under close scrutiny. The first antidote prescribed to achieve cost containment within the health care profession has been a massive dose of increased government regulation. Physicians are having to cope with an increasingly complex set of rules and regulations in order to obtain payment for services either from governmental or commercial third party payers. In addition, physicians have witnessed proposals and programs for direct cost containment legislation, for mandatory second opinion programs, for certificate of need legislation and for professional standard review organizations — all of which are designed, at least in part, to accomplish cost savings.

More recently, it has become apparent that more and more regulation is not the sole solution. An alternative has been suggested in the form of a restructuring of the system, wherever possible, to permit normal competitive market forces to play an increased role. Proponents of the competitive market force remedy have supported legislation designed to foster and encourage the development of health maintenance organizations and other forms of prepaid health care. The ''learned profession'' exemption from the anti-trust laws was largely demolished by the Supreme Court decision in the Supreme Court's *Goldfarb* decision (involving lawyer advertising), and many of the prior ''anti-competitive'' practices in the health care field are now being reviewed and challenged in an effort to inject competitive market forces. The FTC's case against the AMA may be viewed as the tip of a very large iceberg; it seeks to promote the free flow of information to patients so that they can make a more intelligent economic decision when purchasing professional services in the health care field.

In all likelihood, we will find that competitive market forces are not the sole remedy any more than increased governmental regulations. It appears that a balanced approach, considered on a situation-by-situation basis, may provide the best hope for all concerned. Striking such a balance will be difficult, as even our

government is now discovering. For example, on the issue of relative value schedules, we see the Department of Health, Education, and Welfare (wearing the governmental regulation hat) urging the use of these schedules, while at the same time the FTC (wearing the competitive market forces hat) is entering into consent decrees with various medical groups prohibiting the use of such schedules.

In summary, it looks like, for the next several years, politicians, economic theoreticians, lawyers, and doctors will be involved in much discussion, many debates, and extensive litigation over the proper role of government regulation and competitive market forces in the health care field. It is hoped that, during all this controversy about the health and well-being of the patient's pocketbook, doctors will still find the time and energy to keep track of the health and well-being of the patients themselves.

Richard H. Vincent
Legal Counsel to the MAG
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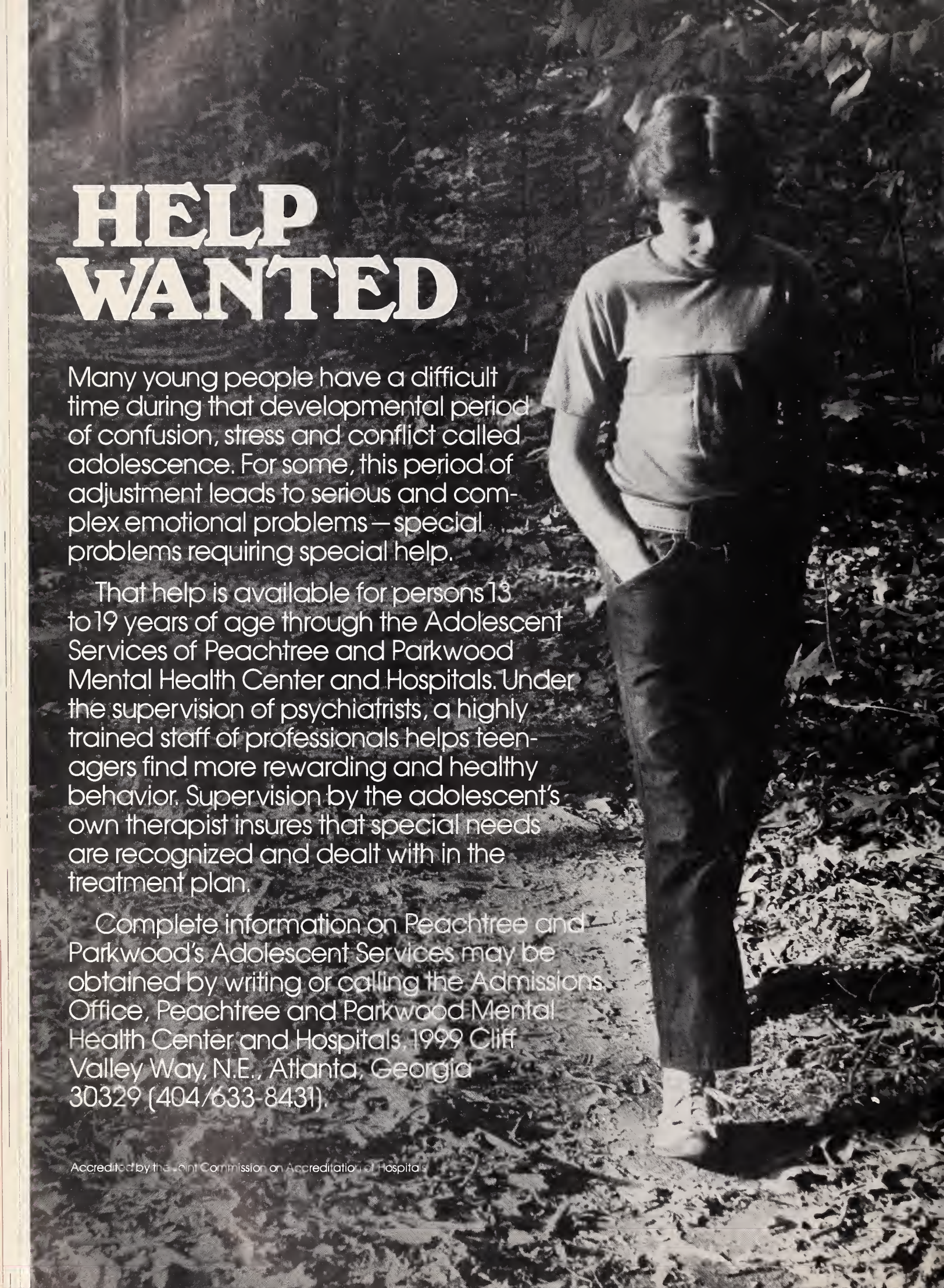
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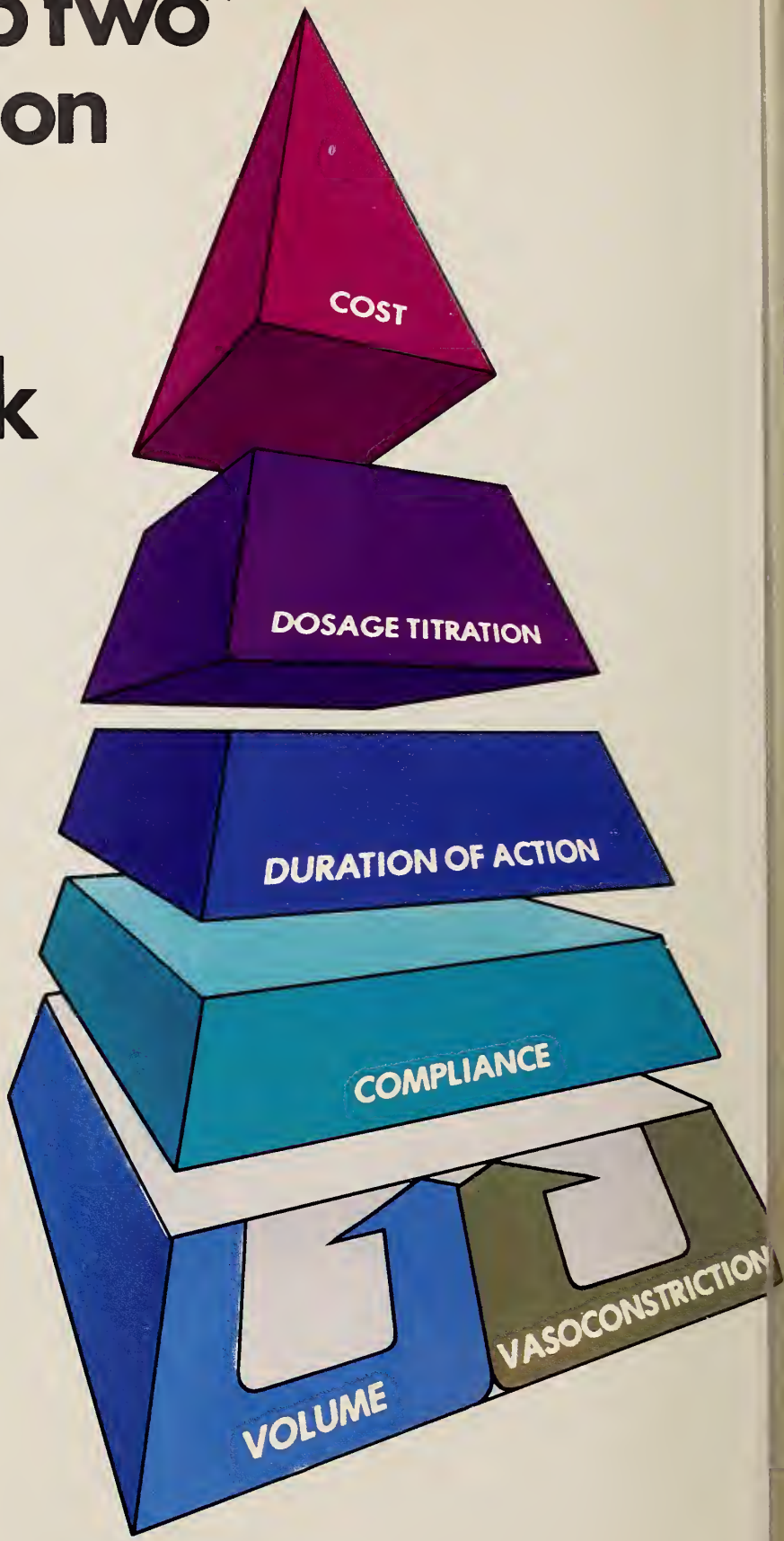


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Salutensin contains the recommended effective doses of both its components, requiring minimal titration.

Duration of action

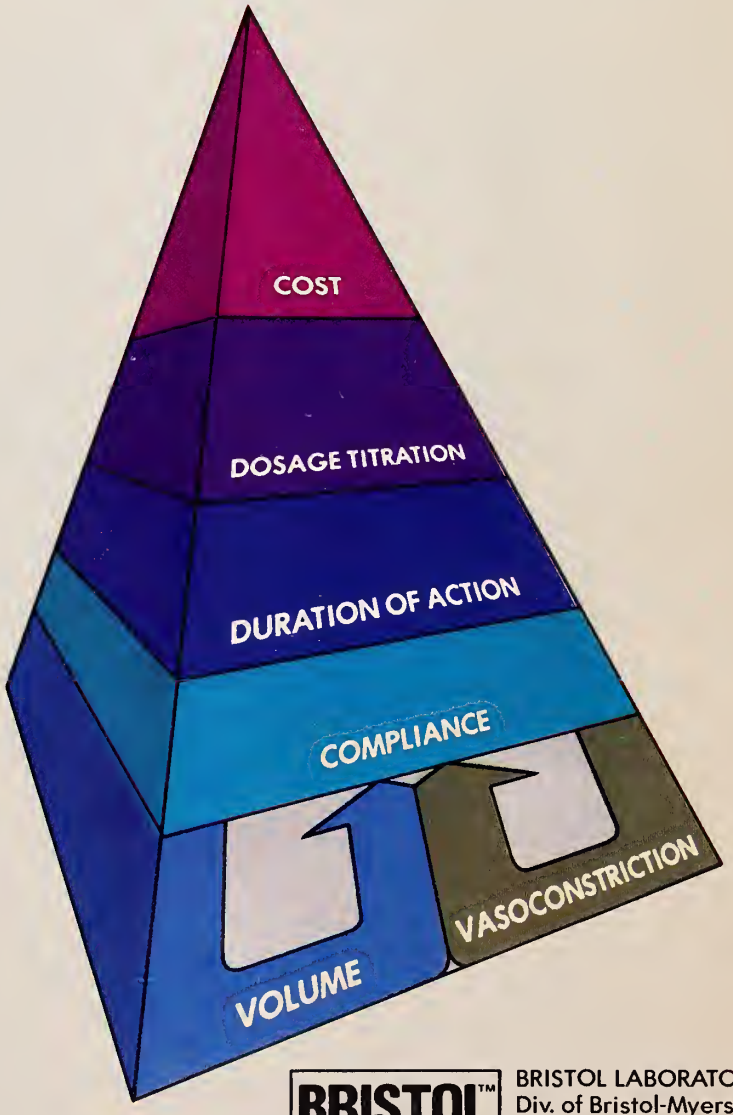
Salutensin contains Saluron (hydroflumethiazide), an intermediate-acting thiazide diuretic, which works over an 18–24 hour period, ideal for once-daily therapy.

Compliance

The total daily dose can be given once a day. Compared with multiple-daily-dosage medications, the chance of a missed dose is greatly reduced.

Volume/vasoconstriction

At the foundation of "step two" hypertension therapy, control of both circulating volume and peripheral resistance can be effectively achieved with the combination tablet Salutensin one day at a time.



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References: 1. Finnerty, F. A. et al.: An Evaluation of Step 2 Regimens in Hypertension, data on file, Bristol Laboratories, 1977. 2. Red Book 1977.

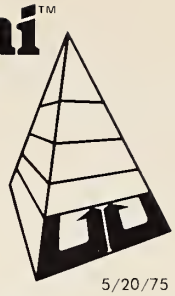
For a summary of prescribing information, please see following page.

Saluron®
(hydroflumethiazide 50 mg.)

Salutensin®
(hydroflumethiazide 50 mg./reserpine 0.125 mg.)

Salutensin-Demi™
(hydroflumethiazide 25 mg./reserpine 0.125 mg.)

structured for the long run in "step two" hypertension



Saluron® (hydraflumethiazide) 5/20/75

For complete information consult Official Package Circular.

CONTRAINDICATIONS: Patients with anuria, oliguria, or hypersensitivity to this or other sulfonamide derived drugs.

WARNINGS: Saluron should be used with caution in severe renal disease. In patients with renal disease, thiazides may precipitate azotemia. Cumulative effects of the drug may develop in patients with impaired renal function.

Thiazides should be used with caution in patients with impaired hepatic function or progressive liver disease, since minor alterations of fluid and electrolyte balance may precipitate hepatic coma. Thiazides may be additive or potentiative of the action of other antihypertensive drugs. Potentiation occurs with ganglionic or peripheral adrenergic blocking drugs.

Sensitivity reactions may occur in patients with a history of allergy or bronchial asthma.

The possibility of exacerbation or activation of systemic lupus erythematosus has been reported.

Usage in pregnancy: Usage of thiazides in women of childbearing age requires that the potential benefits of the drug be weighed against its possible hazards to the fetus. These hazards include fetal or neonatal jaundice, thrombocytopenia, and possibly other adverse reactions which have occurred in the adult.

Nursing mathers: Thiazides cross the placental barrier and appear in cord blood and breast milk.

PRECAUTIONS: Periodic determination of serum electrolytes to detect possible electrolyte imbalance should be performed at appropriate intervals.

All patients receiving thiazide therapy should be observed for clinical signs of fluid or electrolyte imbalance; namely, hyponatremia, hypochloremic alkalosis, and hypokalemia. Serum and urine electrolyte determinations are particularly important when the patient is vomiting excessively or receiving parenteral fluids. Medication such as digitalis may also influence serum electrolytes. Warning signs, irrespective of cause, are: Dryness of mouth, thirst, weakness, lethargy, drowsiness, restlessness, muscle pains or cramps, muscular fatigue, hypotension, oliguria, tachycardia, and gastrointestinal disturbances such as nausea and vomiting.

Hypokalemia may develop with thiazides as with any other potent diuretic, especially with brisk diuresis, when severe cirrhosis is present, or during concomitant use of corticosteroids or ACTH.

Interference with adequate oral electrolyte intake will also contribute to hypokalemia. Digitalis therapy may exaggerate metabolic effects of hypokalemia especially with reference to myocardial activity.

Any chloride deficit is generally mild and usually does not require specific treatment except, under extraordinary circumstances (as in liver disease or renal disease). Dilutional hyponatremia may occur in edematous patients in hot weather; appropriate therapy is water restriction, rather than administration of salt except in rare instances when the hyponatremia is life threatening. In actual salt depletion, appropriate replacement is the therapy of choice.

Hyperuricemia may occur or frank gout may be precipitated in certain patients receiving thiazide therapy.

Insulin requirements in diabetic patients may be increased, decreased or unchanged. Latent diabetes mellitus may become manifested during thiazide administration.

Thiazide drugs may increase the responsiveness to tubocurarine.

The antihypertensive effects of the drug may be enhanced in the postsympathectomy patient.

Thiazides may decrease arterial responsiveness to norepinephrine. This diminution is not sufficient to preclude effectiveness of the pressor agent for therapeutic use.

If progressive renal impairment becomes evident, as indicated by a rising nonprotein nitrogen or blood urea nitrogen, a careful reappraisal of therapy is necessary with consideration given to withholding or discontinuing diuretic therapy.

Thiazides may decrease serum PBI levels without signs of thyroid disturbance.

ADVERSE REACTIONS:

A. Gastrointestinal system reactions: Anorexia, gastric irritation, nausea, vomiting, cramping, diarrhea, constipation, jaundice (intrahepatic cholestatic jaundice), pancreatitis.

B. Central nervous system reactions: Dizziness, vertigo, paresthesias, headache, xanthopsia.

C. Hematologic reactions: Leukopenia, agranulocytosis, thrombocytopenia, aplastic anemia.

D. Dermatologic-Hypersensitivity reactions: Purpura, photosensitivity, rash, urticaria, necrotizing angiitis (vasculitis) (cutaneous vasculitis).

E. Cardiovascular reaction: Orthostatic hypotension may occur and may be aggravated by alcohol, barbiturates, or narcotics.

F. Other: Hyperglycemia, glycosuria, hyperuricemia, muscle spasm, weakness, restlessness.

Whenever adverse reactions are moderate or severe, thiazide dosage should be reduced or therapy withdrawn.

USUAL DOSE: The average adult diuretic dose is 25 to 200 mg. per day. The average adult antihypertensive dose is 50 to 100 mg. per day. Therapy should be individualized according to patient response. This therapy should be titrated to gain maximal therapeutic response as well as the minimal dose possible to maintain that therapeutic response.

HOW SUPPLIED: Saluron (hydroflumethiazide 50 mg.): Bottles of 100.

Salutensin® • Salutensin-Demi™ (12) 10/27/78

(hydraflumethiazide, reserpine antihypertensive farmulatian)

For complete information consult Official Package Circular.

> **WARNING**
> This fixed combination drug is not indicated for initial therapy of hypertension. Hypertension requires therapy titrated to the individual patient. If the fixed combination represents the dosage so determined, its use may be more convenient in patient management. The treatment of hypertension is not static, but must be reevaluated as conditions in each patient warrant.

CONTRAINDICATIONS: Anuria, oliguria, active peptic ulceration, ulcerative colitis, severe depression or hypersensitivity to its components contraindicates the use of Salutensin.

WARNINGS: Small-bowel lesions (obstruction, hemorrhage, perforation and death) have occurred during therapy with enteric-coated formulations containing potassium, with or without thiazides. Such potassium formulations should be used with Salutensin only when indicated and should be discontinued immediately if abdominal pain, distention, nausea, vomiting or gastrointestinal bleeding occurs. Use cautiously, and only when deemed essential, in fertile, pregnant or lactating patients.

Use in pregnancy: Thiazides cross the placenta and can cause fetal or neonatal hyperbilirubinemia, thrombocytopenia, altered carbohydrate metabolism and possibly electrolyte disturbances. Fatal reactions may occur with reserpine during electroshock therapy; discontinue Salutensin 2 weeks before such therapy. Increased respiratory secretions, nasal congestion, cyanosis and anorexia may occur in infants born to reserpine-treated mothers.

PRECAUTIONS: Azotemia, hypochloremia, hyponatremia, hypochloremic alkalosis and hypokalemia (especially with hepatic cirrhosis and corticosteroid therapy) may occur, particularly with pre-existing vomiting and diarrhea. Potassium loss may cause digitalis intoxication. *Potassium loss responds to potassium-rich foods, potassium chloride or, if necessary, discontinuation of therapy.* Serum ammonia elevation may precipitate coma in precomatose hepatic cirrhotics. Discontinue therapy 2 weeks before surgery or if myocardial irritability, progressive azotemia or severe depression occur. Exercise caution in patients with chronic uremia, angina pectoris, coronary thrombosis or extensive cerebral vascular disease or bronchial asthma and in those with a history of peptic ulceration or bronchial asthma; in postsympathectomy patients; in patients on quinidine; and in patients with gallstones, in whom biliary colic may occur. Patients who have diabetes mellitus or who are suspected of being prediabetic should be kept under close observation if treated with this agent.

ADVERSE REACTIONS: Hydraflumethiazide: Skin-rashes (including exfoliative dermatitis), skin photosensitivity, urticaria, necrotizing angiitis, xanthopsia, granulocytopenia, aplastic anemia, orthostatic hypotension (potentiated with alcohol, barbiturates or narcotics), allergic glomerulonephritis, acute pancreatitis, liver involvement (intrahepatic cholestatic jaundice), purpura plus or minus thrombocytopenia, hyperuricemia, hyperglycemia, glycosuria, malaise, weakness, dizziness, fatigue, paresthesias, muscle cramps, skin rash, epigastric distress, vomiting, diarrhea and constipation. **Reserpine:** Depression, peptic ulceration, diarrhea, Parkinsonism, nasal stuffiness, dryness of the mouth, weight gain, impotence or decreased libido, conjunctival injection, dull sensorium, deafness, glaucoma, uveitis, optic atrophy, and, with overdosage, agitation, insomnia and nightmares.

USUAL DOSE: 1 tablet b.i.d.

HOW SUPPLIED: Salutensin (hydroflumethiazide 50 mg., reserpine 0.125 mg.): Bottles of 100 and 1000.

Salutensin-Demi (hydroflumethiazide 25 mg., reserpine 0.125 mg.): Bottles of 100.

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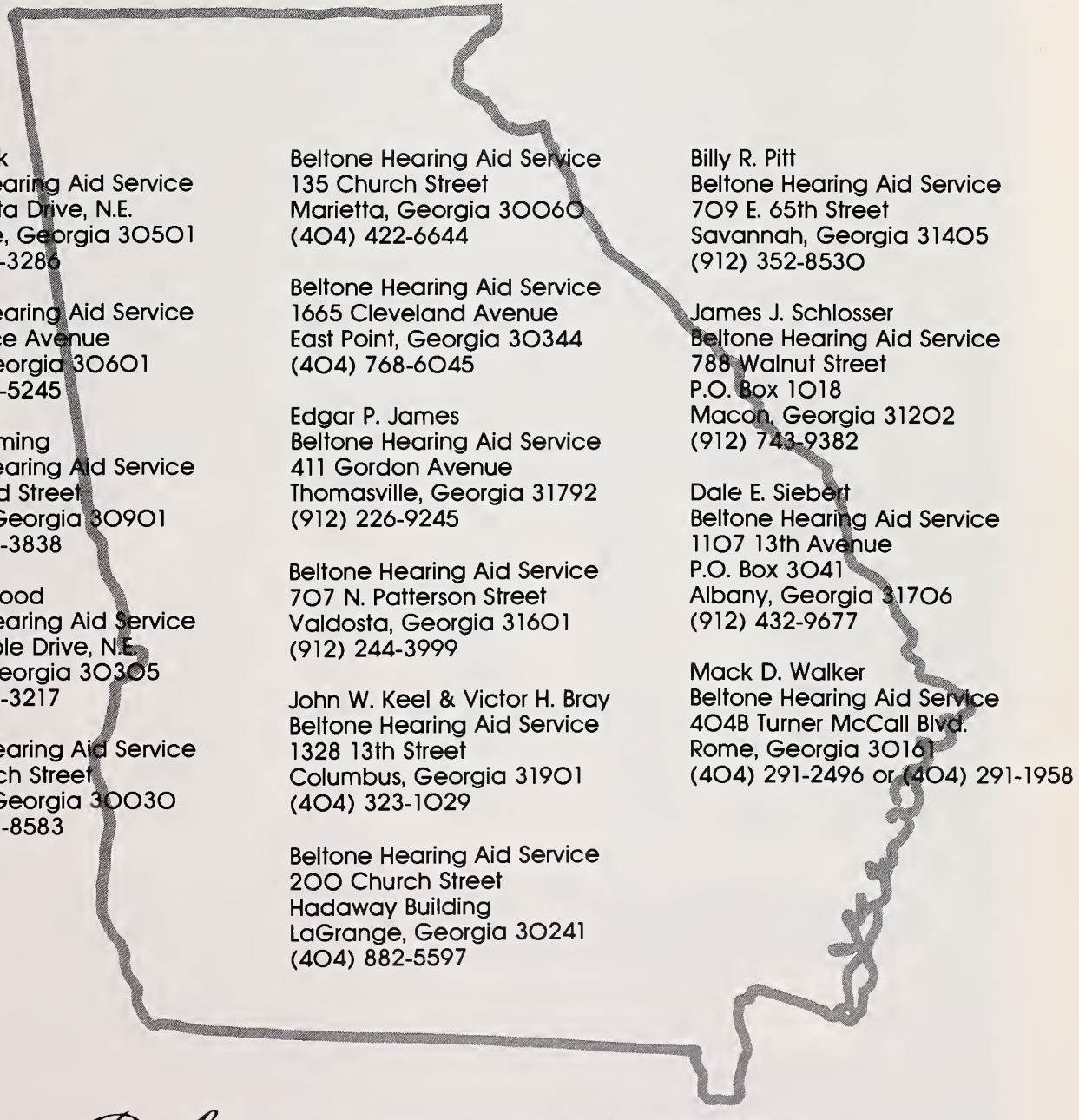
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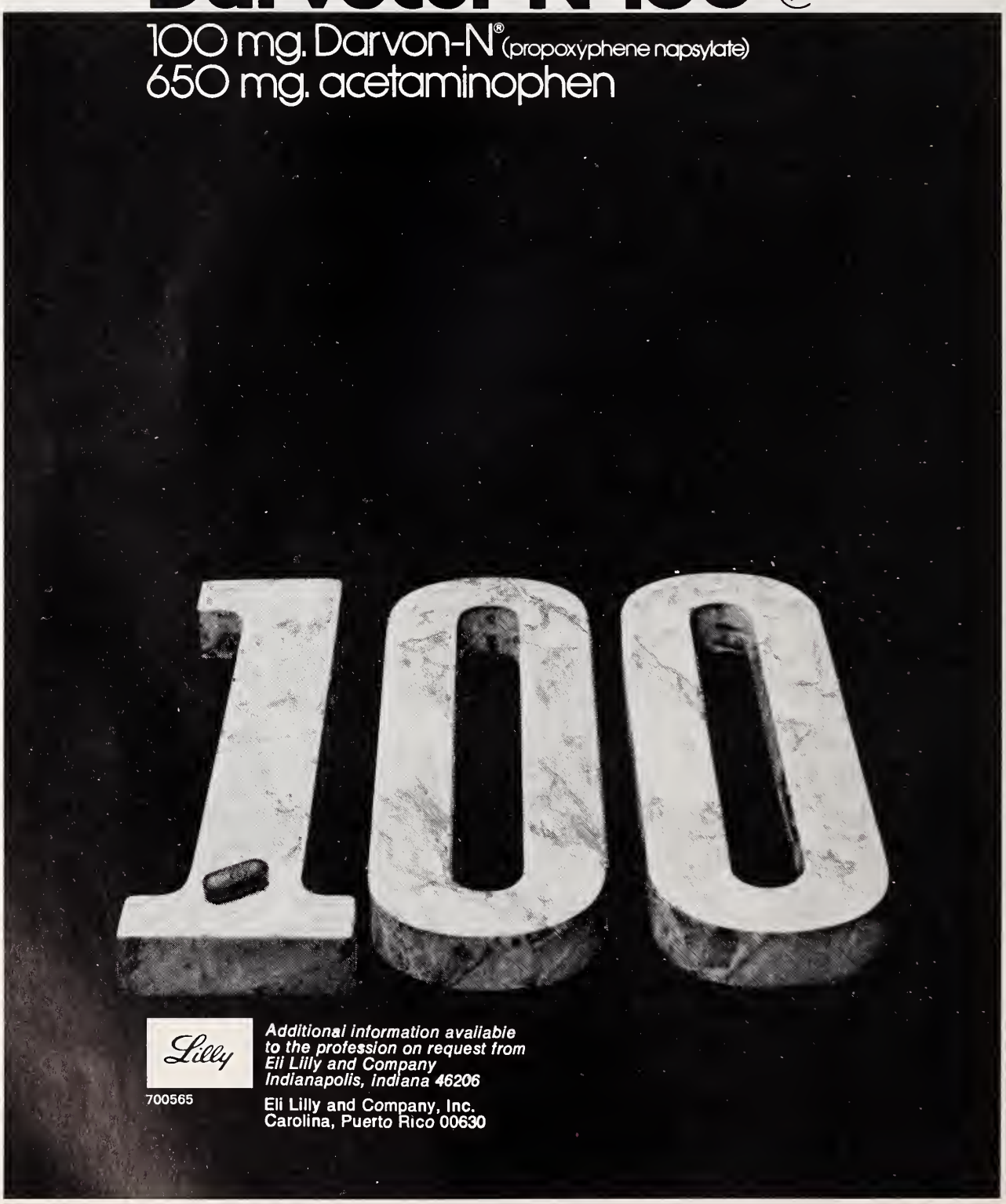
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Continuing Medical Education in Oncology

THOMAS W. PHILLIPS, M.D., *Atlanta**

THE PRACTICE OF MEDICINE has changed greatly in America over the past 50 years. The small-town doctor who was forced to practice medicine which encompassed all aspects of medical and surgical care has been replaced by specialists and sub-specialists. This evolutionary process, whether desirable or not, was inevitable due to the growing complexities associated with the advancement of medicine in general.

A similar evolutionary process has taken place in the treatment of cancer patients. Surgical oncology, medical oncology, and radiologic oncology are separate but related disciplines requiring prolonged specialized training and recognized by different specialty Boards. There is even sub-specialization within these specialty fields. The development of new treatment forms for cancer patients often includes all three treatment modalities, so that coordination between the specialists is necessary. The cooperative combined approach to planning treatment in cancer patients has the greatest chance for meaningful impact on prolonging survival and improving the quality of life when applied early in the treatment of a newly-diagnosed cancer patient.

New ideas in cancer management are constantly being developed. It is imperative that these ideas be considered carefully and discussed among cancer therapists before being put into general use. Each oncologic specialty has its own national society or societies upon which the physician depends greatly for continuing medical education. The national meetings of the various societies are usually not inter-disciplinary in character.

A new organization has been formed to specifically meet the needs of interdisciplinary continuing medical education in oncology in Georgia. This new organization is called The Clinical Oncology Association of Georgia and is based in Atlanta. The general format of the meetings is a dinner, followed by a guest speaker, usually from a cancer center outside the Southeastern United States. An attempt is made to obtain speakers from various backgrounds and areas of emphasis who can present divergent opinions.

The first meeting of the Association was held on September 6, 1978, at Brennan's Restaurant in Buckhead, Atlanta. The speaker was Stephen Rosenburg, Chief of Surgery at the National Cancer Institute. His topic was "A General Overview of Cancer Therapy Today."

* Dr. Phillips is the President of the Clinical Oncology Association of Georgia. His address is 25 Prescott St., NE, Atlanta, GA 30308. This paper was prepared at the request of the Georgia Division, American Cancer Society. Others wishing to contribute papers to this page are invited to send them to David B. Roberts, M.D., 2400 13th St., Columbus, Ga. 31906.

The second meeting was on October 18, 1978, at the Midnight Sun Restaurant in Peachtree Center. The speaker was Emil J. Freireich, Head of the Department of Developmental Therapeutics at M. D. Anderson Hospital in Houston, Texas. His topic was "An Overview of Cancer Therapy in the United States Today."

The most recent meeting was held on January 17, 1979. The speaker was Dr. Eleanor Montague, Professor of Radiation Therapy at M. D. Anderson Hospital in Houston, Texas, who spoke on "Current Concepts in the Treatment of Breast Cancer." Later in 1979, Dr. Willet Whitmore from Sloan-Kettering Memorial Hospital in New York, Department of Urology, will speak on "Similarities of Breast Cancer and Prostate Cancer." Other outstanding oncologists will be featured in the future.

Membership in the organization is open to all physicians who have an interest in cancer care. Physicians' assistants, nurses, and technicians are also invited to attend the meetings. The organization has been approved for continuing medical education by the American Cancer Society, Georgia Division, and the President of the organization is a permanent member of the Professional Education Committee of the American Cancer Society.

For those who wish more information, the address for The Clinical Oncology Association of Georgia is P. O. Box 76356, Atlanta, GA 30308.

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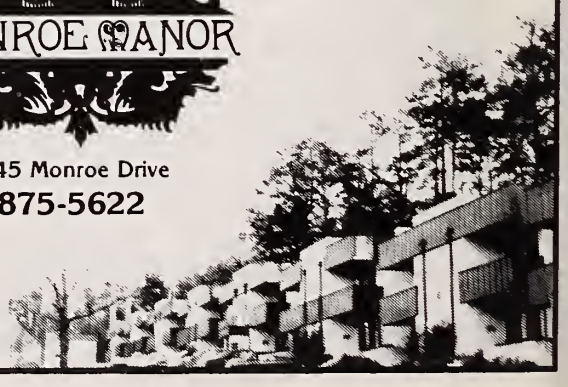
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Packer, Robert M., III, Ware—N2—IM
110 Thomas St., Waycross 31501

Smith, Richard C., Walker-Catoosa-Dade—N2—FP
P.O. Box 967, LaFayette 30728

Tark, Marvin Denny, Cobb—N2—AN
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Thomas, Brenda H., Colquitt—ACT—PD
3011 4th St., SE, Moultrie 31768

Tuley, R. David, Coweta—N2—GS
33 SW Upper Riverdale Rd., Riverdale 30274

Ware, James Patrick, MAA—A—CHP
P.O. Box AF, Emory University, Atlanta 30322

Warren, James Earl, Cobb—ACT—AN
754 Cherokee St., Marietta 30060

PERSONALS

First District

J. Robert Logan, M.D., was elected President of the Georgia Medical Society at its annual meeting. Dr. Logan succeeded **Dearing Nash, M.D.,** as head of the society. Also elected were **Dan H. Willoughby, M.D.,** President-elect; **Roland Summers, M.D.,** Vice-President; **Eloise B. Sherman, M.D.,** Secretary; **J. Lane Reeves, M.D.,** Treasurer; **David Robinson, M.D.,** Historian; and **Edgar J. Filson, M.D.,** Parliamentarian.

Frank T. Robbins, M.D., has opened a second office in Reidsville near the Tattnall Memorial Hospital. Dr. Robbins will maintain his practice in Hinesville also.

Stephen Robert White, M.D., of Statesboro was initiated as a Fellow of the American College of Surgeons at its 64th Annual Clinical Conference in San Francisco, California.

Third District

T. J. Rundle, M.D., has been named Chief of Staff at the Americus and Sumter County Hospital, effective January 1, for a 2-year term. He and James R. Griffith, administrator of the county hospital, attended a meeting of the Hospital Medical Staff Conference held at Pacific Grove, California, near Monterey.

H. A. Wasden, III, M.D., of Manchester has been named a Fellow of the American Academy of Family Physicians.

Fourth District

Covington physician, **Ernest J. Jones, M.D.,** has been named Tenth District alternate director of the Georgia Academy of Family Physicians. Dr. Jones was installed in the office during ceremonies in Atlanta, part of the Academy's annual meeting.

William E. Silver, M.D., of Atlanta has been named President-elect of the medical staff of Shallowford Community Hospital.

Ralph Tillman, M.D., has been elected Chief of Staff of the DeKalb General Hospital.

Fifth District

Steven L. Sanders, M.D., an Atlanta general surgeon, was elected President of the medical staff of the Crawford W. Long Hospital of Emory University. Dr. Sanders is a clinical assistant professor of surgery at Emory University School of Medicine.

Atlanta surgeon, **Frank L. Wilson, M.D.,** has been elected President-elect of the Medical Association of Atlanta, and is slated to serve as President of the 1450-member organization in 1980. The election came at the Association's annual meeting at which **William C. Collins, M.D.,** was installed as 1979 President, succeeding **Charles E. Harrison, Jr., M.D.** Other officers elected for 1979 were **William B. Spearman, M.D.,** Secretary, and **Bob G. Lanier, M.D.,** Treasurer.

Sixth District

After practicing a year and a half in Macon, **Patrick J. Moore, M.D.,** has opened his own psychiatric practice in Warner Robins.

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Seventh District

Anthony Cabot, M.D., has been named a diplomate of the American Board of Orthopedic Surgery.

Ray E. Dellinger, M.D., Philip Z. Israel, M.D., and **Oliver W. King, M.D.,** have opened an additional office at 833 Campbell Hill St. in Marietta. **Robert Parham, M.D.,** has also moved his office to the same location.

Paul Ferguson, M.D., was the featured guest on a segment of "Check-Up," a video production of Tri-County Regional Library in cooperation with Rome Cable TV. Dr. Ferguson, a neurosurgeon, discussed head and back injuries with **Robert Farrell, M.D.,** "Check-Up" host.

Mark A. Gould, M.D., medical director of Brawner Psychiatric Institute, Smyrna, has been elected chairman of the Accreditation Council for Psychiatric Facilities for the Joint Commission on Accreditation of Hospitals.

Ninth District

Elton L. Copelan, M.D., of Toccoa, has opened an office in Habersham County. Dr. Copelan has practiced obstetrics-gynecology at the Toccoa Clinic since 1962.

SOCIETIES

The Cobb County Medical Society has elected officers for 1979. The new officers are Frank McKinnon, M.D., President; Spencer Mullins, M.D., President-elect; and Charles Rey, M.D., Secretary/Treasurer.

With the support of the Cobb County Medical Society and the participation of the Auxiliary to the Society, the Cobb County School Board has established a yearly scoliosis screening program. The purpose of this program is to screen all children in the middle school system (grades 6, 7, and 8) in Cobb County for scoliosis. This year's screening took place in January and February. Those children who have the symptoms of scoliosis were referred to their family's physician pediatrician, or orthopedist.

The newly-formed **Douglas County Medical Society** has elected their officials. Hector J. Curiel, M.D., was elected chairman of the society for a 1-year tenure. Named as Vice Chairman was Carlos A. Selmonosky, M.D.; A. Clark Robinson, M.D., will serve as Secretary-Treasurer. The purpose of the society is to promote the science and art of medicine and the betterment of public health. Every physician residing and practicing in Douglas County and area counties is eligible for membership as they request.

The **Ware County Medical Society** has elected their officers for 1979. Michael J. O'Connell, M.D., was named President; Lawrence J. Duane, M.D., Vice-President; and Howard A. Griffin, Jr., M.D., Secretary-Treasurer.

DEATHS

J. Lon King, Sr.

J. Lon King, Sr., M.D., aged 90, of Macon died December 6, 1978. Dr. King retired in 1968 after having practiced medicine for 50 years.

Born in Newton County, he received his M.D. degree from the Emory University School of Medicine in 1916 and interned at University Hospital in Augusta and St. Luke's Hospital in Jacksonville, Florida. He was a contract surgeon for the U.S. Army during World War I. In 1918, he moved to Macon and set up a private practice.

Dr. King and four other doctors opened Oglethorpe Private Infirmary in 1919. The hospital was sold to the Sisters of Mercy in 1942. He was on the staffs of the Medical Center of Central Georgia and Coliseum Park Hospital, a past president of the Bibb County Medical Society, a member of the Medical Association of Georgia, and a member of the American Medical Association. He attended the First Presbyterian Church.

Survivors include a son, a daughter, two grandsons, four granddaughters, and six great-grandchildren. A contribution was made by the Bibb County Medical Society to the Max Mass Library, Medical Center of Central Georgia, in his honor.

Marcus Mashburn, Sr.

Marcus Mashburn, Sr., M.D., 88, died on December 7, 1978, following an extended illness. He was one of Forsyth County's leading business and civic leaders.

Dr. Mashburn was a graduate of Emory University Medical School, Class of 1915, and had been practicing medicine in Forsyth County since that time.

He served as mayor of Cumming from 1961 to 1966 and served in the Georgia Legislature in both the Senate and House of Representatives. Dr. Mashburn served the local educational field as a Trustee of Cumming High School until the county schools were consolidated and as a member of the local Board of Education. Mashburn Elementary School was named in his honor in 1977.

Dr. Mashburn was a charter member of the Chattahoochee Medical Society, the Medical Association of Georgia, and the American Medical Association. He had a keen interest in history and was made an honorary member of the Forsyth County Historical Society. He was a member of the Cumming United Methodist Church, where he had served in many administrative positions.

He is survived by his wife, two sons, nine grandchildren, two great-grandchildren, and a number of other relatives.

Raymond Suarez

Raymond Suarez, M.D., 78, of Macon, died of a heart attack at his home on December 8, 1978. Born in Havana, Cuba, he came to the United States in 1914. He attended Norman Park College and was a graduate of Emory University, Mercer University, and the Medical College of Georgia.

Dr. Suarez practiced in Macon from 1934 until his retirement in 1973. He was a charter member of Highland Hill Baptist Church, the American Medical Association, the Medical Association of Georgia, the American Sterility and Infantility Association, the Macon Civitan Club, Idle Hour Country Club, and a life member of the Macon Elks Club.

Survivors include his wife, Evelyn Swilling Suarez, M.D., and a sister. The Bibb County Medical Society made a contribution to the Max Mass Library, Medical Center of Central Georgia, in his honor.

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Physician's Recognition Award Recipients

LISTED BELOW *are those physicians in Georgia who have earned the AMA's Physician's Recognition Award from March through June 1978.*

The award was established in 1969 "to recognize, encourage and support physicians who participate regularly in continuing medical education and to emphasize the importance of developing more meaningful continuing medical education opportunities for physicians." A minimum of 150 credit hours of CME must be earned over a three-year period to qualify for the award. The hours may include such activities as conferences, residencies, teaching, writing, private reading, listening to cassettes, home study courses, consultation, and peer review; at least 60 of the hours, however, must be from formal CME programs sponsored or co-sponsored by organizations accredited for these activities.

We congratulate the following physicians who have distinguished themselves and their profession by their commitment to continuing education:

Norman Abramson, Macon
Alfred Agrin, Gainesville
Ricardo B. Akstein, Atlanta
Kenneth Braulio Alonso, Atlanta
Henry Alperin, Augusta
John Carl Ammons, Decatur
John Lee Anderson, Macon
James Lewis Askew, Riverdale
Charles Edward Bagley, Alma
Clyde Edward Black, East Point
David Morton Boyette, Albany
Robert Gardner Bradbury, Savannah
Nyda Williams Brown, Atlanta
Samuel Edward Brown, Atlanta
Ralph William Buchanan, Augusta
James Bricker Burns, Marietta
Benjamin B. Cala, Columbus
David Arthur Causier, Decatur
Kwong-Nan Chen, Dublin
James L. Clements, Atlanta
Wilber T. Clonts, Marietta
Hewlette Collier Connell, Macon
Justin Lyle Conrad, Atlanta
Carl LeRoy Crawford, Warner Robins
Glenn Dale Crawford, Austell
William Elon Dalton, Calhoun
Frank Thomas Daly, Atlanta
Ernest F. Daniel, Augusta
Robert L. Davies, Atlanta
Billy Joe Davis, Hartwell
William A. Davis, Atlanta
Elwin William Donnelly, Atlanta
Richard Warren Eels, Decatur
Dan Berlin Elrod, Hazlehurst
Nizami Vildan Erkan, Atlanta
Albert Louis Evans, Atlanta
Edwin Curtis Evans, Atlanta
Robert Merril Fine, Decatur
Arlie Eugene Fiveash, Augusta
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Another New Member Joins the MAG Staff

Robert M. "Bert" Franco became a member of the MAG staff on December 1, 1978, assuming the position of Assistant Director of Medical Practice. He will be working in the areas of health planning, access to health care, third party relations, emergency medical services, Medicaid negotiations, and laboratory quality.

Mr. Franco, a native of Atlanta, came to MAG from the Health Systems Agency of Central Georgia, where he was a health planner for 15 months. Prior to that, he attended the University of Florida, Gainesville, where he received both Bachelor's and Master's degrees in Applied Medical Anthropology. He brings to this job considerable knowledge of government involvement in the practice of medicine.



Robert M. "Bert" Franco

A Report from MAG's Nutrition Committee on Fiber

The Nutrition Committee of the Medical Association of Georgia has viewed with much interest the burgeoning research in the area of fiber intake and its possible relationship to health maintenance. Of particular interest to this committee is experimental evidence which suggests that certain components of fiber, notably pectin, may be effective in lowering serum cholesterol and improving glucose tolerance. Although much more research is needed in order to document the actual benefit of fiber components in prevention of disease, the suggestion that some benefit may exist prompts the committee to bring this dietary substance to the attention of the public. We have long known that sufficient fiber in the diet can be most helpful in regulating bowel habits and often can eliminate the need for laxative medications. Therefore, since dietary fiber possesses proven benefit in regulating bowel habits and possible benefit in deterring development of certain degenerative diseases, the committee would like to recommend that each Georgian evaluate his or her usual dietary habits in relation to intake of dietary fiber.

The following questions will prove helpful in assessing whether or not dietary fiber is a recognized constituent of the daily diet:

1. Are whole grain breads and/or cereals eaten regularly?
2. Are legumes often substituted for meat as a source of protein?
3. Are vegetables, often raw, eaten every day?
4. Are the skins of baked potatoes, baked apples, etc., consumed as part of the vegetable/fruit?
5. Are raw fruits often eaten as desserts or snacks?

If answers to all these questions are "yes" then more than likely a minimum of 30 grams of fiber daily is being consumed. The range of fiber intake, which appears feasible and probably desirable in most instances, is 30-60 grams daily.

TABLE 1
FOODS WITH A HIGH FIBER-ENERGY RATIO

Food	Portion Size	Kilocalories	Fiber-Energy Ratio
Wheat flour, whole grain	2½ Tbsp.	60	3.0
Rye wafers	3 squares	64	3.5
Cantaloupe	½ cup	26	3.6
Wheat cereal, shredded	1 lg. pillow	84	3.62
Wheat cereal, flakes	¾ cup	75	3.93
Plums	2 medium	58	4.0
Bread, whole wheat	1 slice	63	4.2
Rye flour, dark	2½ Tbsp.	60	4.7
Orange	1 small	45	4.7
Beans, white	½ cup	91	4.7
Potatoes, white	1 small	80	4.8
Beans, kidney	½ cup	94	4.8
Bread, rye	1 slice	54	5.0
Corn, kernels	⅓ cup	41	5.2
Tangerines	1 medium	34	5.3
Strawberries	¾ cup	36	6.6
Apples	1 small	55	7.1
Squash, winter	½ cup	43	8.3
Cucumbers (raw)	½ cup	7	10.7
Carrots	½ cup	19	11.6
Peas	½ cup	44	11.8
Blackberries	½ cup	30	12.2
Radishes (raw)	½ cup	9	13.8
String beans	½ cup	12	14.2
Cabbage (raw)	½ cup	11	14.7
Bran (100%) cereal	½ cup	66	15.1
Lettuce (raw)	½ cup	3	16.7
Broccoli	½ cup	15	17.1
Squash, summer	½ cup	9	25.0
Zucchini	½ cup	9	27.3
Celery	½ cup	5	33.3

One serendipitous aspect of the diet designed for its high fiber content is that foods contained therein are usually fairly low in calories. High fiber foods, for the most part, are quite bulky, and weight for weight are lower in calories than are those which are more compact. Foods high in fiber then, because of their volume, have an increased satiety value and when used appropriately (i.e., substituted for other foods rather than added to an existing diet) can be most helpful in weight control.

Fiber-energy ratio is a term used to describe *the grams of fiber which may be obtained from that amount of a food supplying 100 kilocalories.*

In summary, the committee suggests that each person assess his/her own eating habits. When fiber consumption appears to fall below 30 grams daily, and no organic condition exists which requires fiber restriction, the committee recommends that substitutions be made in the diet so as to increase the fiber content. Such substitutions include: 1) use of whole grain bread and/or cereals in place of refined ones, 2) generous use of raw fruits and vegetables to replace high caloric desserts, casseroles, and pastries, 3) increased use of legumes as a source of protein to replace the over abundance of meat often consumed. A diet modified as described should prove to be beneficial, not only because of its increased fiber content, but also because of its potential for lowering energy intake, particularly that contributed by fat.

(This report has been approved by MAG's Board of Directors. Special thanks to Sara Hunt, Ph.D. for her assistance in preparing this report. Reprints are available on request, as are additional information and bibliography.)

Dial Access Program Sponsored by the SMA

The Southern Medical Association (SMA) has organized the Dial Access Program, a method of medical consultation by means of tape-recorded messages that are accessible by request through long distance, toll-free telephone calls. The Dial Access Program is designed to provide the most recent diagnostic and therapeutic information available on specific problems. Each program operates through a bank of over 100 taped messages, written by noted authorities on the particular disease. The system is approved for credit toward the AMA Physician's Recognition Award, and by simply listening to these tapes, you may accumulate Category V credit. Dial Access is available 24 hours a day, 7 days a week, and it is free.

Based on the success of the Cancer Program, SMA recognized the potential for the Dial Access System and began the expansion of this viable program into other medical areas. The Dial Access Program on Arthritis and Rheumatology, sponsored by McNeil Laboratories, is the first of the new programs to be made available.

By the Spring of 1979, three more Dial Access Programs will be introduced: Infectious Diseases, sponsored by Eli Lilly and Company; Obstetrics/Gynecology and Gastroenterology, both sponsored by Ortho Pharmaceutical Corporation. For further information regarding these programs, contact Roy Evans at the SMA in Birmingham, Alabama, phone (205)-323-4400.

Morehouse College Medical Students in Clinical Preceptorship Program

Over 40 Atlanta physicians are participating in a special program designed to give students at the new School of Medicine at Morehouse College a first-hand look at the practice of medicine. The project, a clinical preceptorship program, pairs Morehouse students with physicians for several hours each month, enabling the student to observe the physician in various clinical settings, including hospitals, clinics, and physician offices.

Dr. Calvin Sinnette, Associate Dean for clinical affairs at Morehouse, said that the physicians in the program are serving on a volunteer basis and "are making a valuable contribution to the school's educational program."

Dr. Joseph Williams, an Atlanta physician and part-time medical school faculty member, is serving as coordinator of the program. He said the students spend about 6 hours with their receptors per month. "They go everywhere with the physician during that period of time and participate in hospital rounds and other clinical activity," he said.

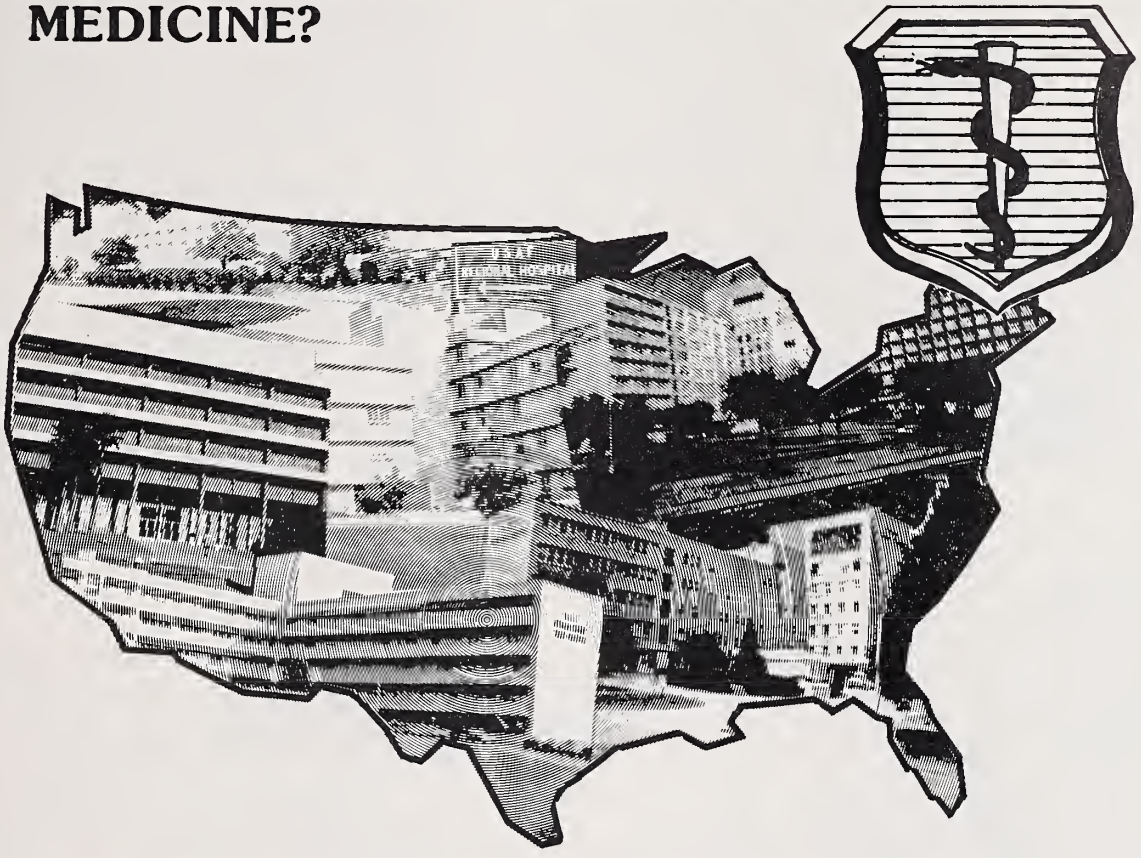
According to Sinnette, plans call for the continuation of the clinical preceptorships during the second year of the students' education and for an expansion of the number of physicians participating.

The School of Medicine at Morehouse College opened in September as the first medical school to be founded at an historically-black college in the United States in the 20th century.

The School presently offers a 2-year program in the basic medical sciences. Students enrolled at Morehouse will transfer to various 4-year medical schools to complete their education.

The Morehouse Medical School is scheduled to evolve into a 4-year, degree-granting institution in the mid-1980's.

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I've told this before . . .

The Nudist Colony

IT MUST HAVE BEEN in the late 40's or early 50's . . . anyway, it was a long time ago that the late Dr. Tom Godwin and I and another man were fishing at the mouth of the Combahee River in Beaufort, South Carolina. We were going to fish for flounder at low tide, but we had arrived early, anchored, and cast our lines. We weren't really expecting anything, since no respectable flounder will bite unless the tide is "just so," and Mr. Flounder was true to his reputation. It was hot; we sweated, drank beer, and talked. The third man in our boat was an elderly lawyer from Beaufort, named Mr. Bremer. He told us an interesting story about the time that a nudist colony came to Beauford County.

"Along in May some years ago," said Mr. Bremer, "two avid trout fishermen — a fellow by the name of Joshua Cooper and another by the name of Ben Morrison pulled in at the old dock on the Azilia peninsula. The peninsula at one time housed several families whose livelihood consisted of fishing, hunting, and truck farming, but the last old folks had died the previous year, leaving only the old houses and "grown-up" garden areas. Anyway, Ben and Joshua eased into the ramshackled dock to fill their water jug from the flowing well some 20 steps up on the peninsula. They noted a new "Posted" sign, but paid little or no attention to it.

Joshua, who was waiting for Ben to fill the jug, happened to glance up toward the old house and saw men, women, and children working in one of the old garden areas. This surprised him a little bit, since he hadn't expected to see anyone but what made him do a quick double take was that they did not have any clothes on!

Then, a bare-footed man approached them, looking as though he had just slipped on a pair of trousers. He pointed to the "Posted" sign on the land and a "No Trespassing" sign on the dock. But before he could say anything, Ben and Joshua both explained that they had fished these waters for years and had always depended on this well to fill their water jug.

Speaking with a distinct New England accent, the man explained that they were a group of "sun worshippers" and had leased the peninsula, had it posted, and did not want to be disturbed unless it was by someone interested in joining the colony. He was adamant and wanted this to be clearly understood!

Ben and Joshua got back in their boat (with a full water jug), shoved off, and headed straight for home. By late afternoon all of Beaufort was atwitter with the news of a nudist colony on Azilia peninsula. That's all they talked about for days. The men treated it more or less as a joke and made all sorts of wise cracks, but the women were upset, and they stirred up the preachers. The preachers in turn discussed it with the deacons, the stewards, and the elders. Then a group from each church was formed, and together they took their grievance to the sheriff.

The sheriff listened patiently, then explained that the so-called colonists were not breaking any law now on the books. He said they were quiet, orderly, and minding their own business, and since they had a bona fide lease, they had every legal right to be there. As an afterthought, he said, "And after all, they claim to be a religious group." That didn't appease either the women or the preachers.

Then the sheriff made them this proposition: They would all go to the colony and meet with its leaders, to see if something could be done. "You preachers," he added, "might even convert them away from their unusual worship." Then he paused a few seconds and said, "Of course, we may have to take off our clothes to meet with them." The preachers squirmed a little bit but remained silent. The ladies, however, vociferously opposed his suggestion. One preacher's wife said

that there were enough sinners in Beaufort County with their clothes on to keep all the preachers busy. She said she didn't want her undressed husband trying to convert an undressed female sinner. The women were further upset by reports of the nudists, male and female, adults and children, swimming and playing together. The meeting adjourned with the sheriff promising to call the Governor to see if there was any law they could use to evict the nudists. They agreed to meet the following Sunday at St. Helenes Church.

The Governor's response was as predicted; the nudists were not violating any law currently on the books. At the appointed time 1 week later, the sheriff arrived at the church. Some citizens remember that when the sheriff stepped out of his car, he gazed for a long time at some nearby trees being tossed and ruffled by the wind. As he approached the church, he hitched up his belt, adjusted his wide brim hat, paused to glance heavenward, then took off his hat, and entered the crowded church.

The minister brought the meeting to order, said a short prayer, and called on the sheriff. He rose and faced those assembled. In the loud voice he often used with convicts and prisoners, he said, "Ladies and gentlemen, the nudists will be off the Azilia peninsula by sundown tomorrow." And with that, he turned and left. He was not seen or heard from for 2 days. And, sure enough, the nudists vacated the peninsula before sundown the following day.

Now there was much conjecture about what the sheriff had done, what methods he had used. The answer was supplied by an old black man, Rusty, the trusty, who looked after the sheriff and drove his car.

Said Rusty, "When de sheriff got up dat Sunday mawning, he look worried. He walk around de jail, and he slap some mosquiters off his arms. Den some deer flies start biting him on his arms. Den he looked up, and saw de east wind blowing, and (he ain't lived here all his life for nothing) he knows dat if dat east wind blows for 3 or 4 hours, it will blow for 3 or 4 days. When he got to de church and de east wind was still blowing, he knowed it would keep on for 3 or 4 more days. And he knowed dat it would blow all de mosquiters and de deer flies and de sand flies and de no-seems from the swamp lands out on the Zilla peninsular, and de ain't no Yankee can barely stay out dere wid hiz clothes on. And de ain't no way — no way — if he's nekkid!"

J. G. McDaniel, M.D.
Atlanta, GA

(Editor's note: Others wishing to contribute to this page should send their stories to the attention of the Managing Editor of the Journal.

Doctor of Pharmacy Degree Now Available at Mercer

Mercer University's School of Pharmacy in Atlanta will become the first pharmacy school in the Southeast to offer the doctor of pharmacy degree as its sole professional degree. The change to the single degree will take place with the entering class in September of 1981. The bachelor of science degree in pharmacy will not be offered after the 1980 entering class.

The doctor of pharmacy program is directed by Dr. Laurel Ashworth, a graduate of the University of California in San Francisco, who said, "The Mercer School of Pharmacy will be a prototype for other private pharmacy colleges attempting to undertake a clinical approach to pharmaceutical education."

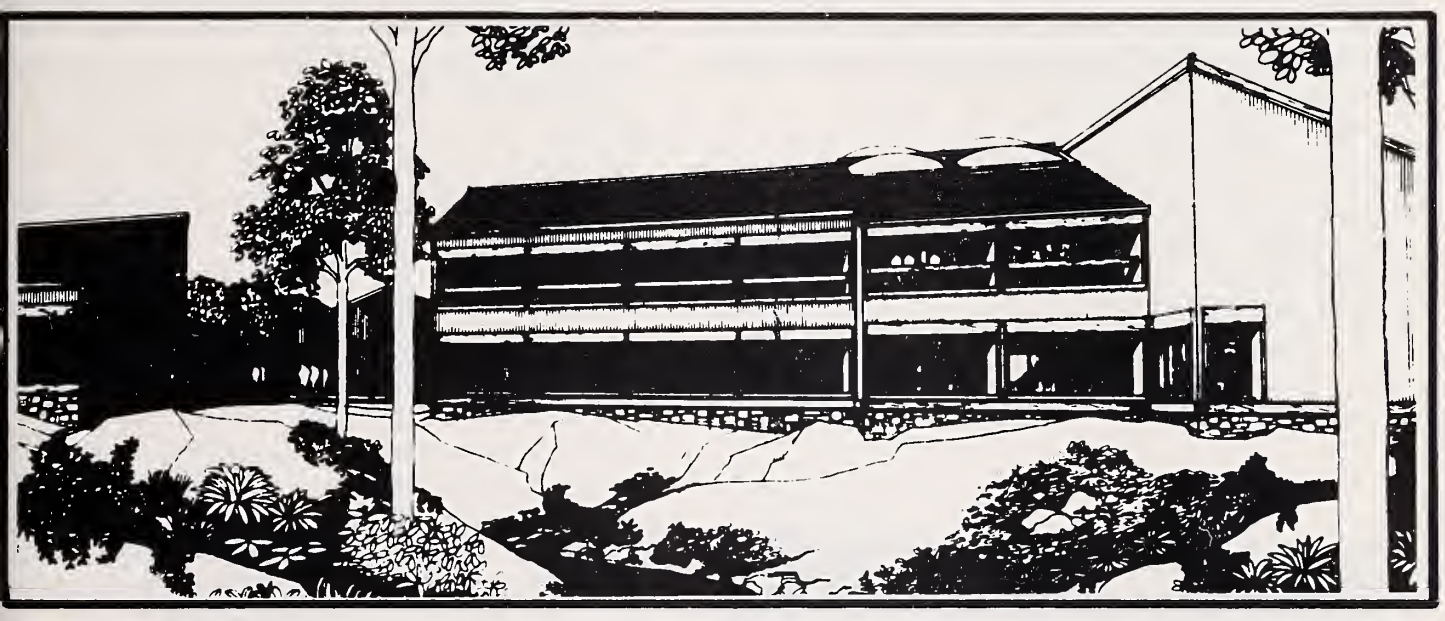
"The only other schools in the United States currently offering the doctor of pharmacy degree are the University of California, the Univeristy of Southern California, and the University of Nebraska Schools of Pharmacy."

President Harris said the school has made considerable advancement in the area of clinical pharmacy under the leadership of Dr. Ronald Maddox, chairman of the Department of Clinical Pharmacy.

Dr. Maddox has been instrumental in establishing clinical training programs with Georgia Baptist Hospital, Grady Memorial Hospital, Doctors Memorial Hospital, Veterans Administration Hospital, Georgia Mental Health Institute, Georgia Retardation Center, West Paces Ferry Hospital, Fulton County Alcohol Detoxification Center, and DeKalb County Mental Health Center. In addition to these training sites, several pharmacies have been approved as external clinical training sites for Mercer students.

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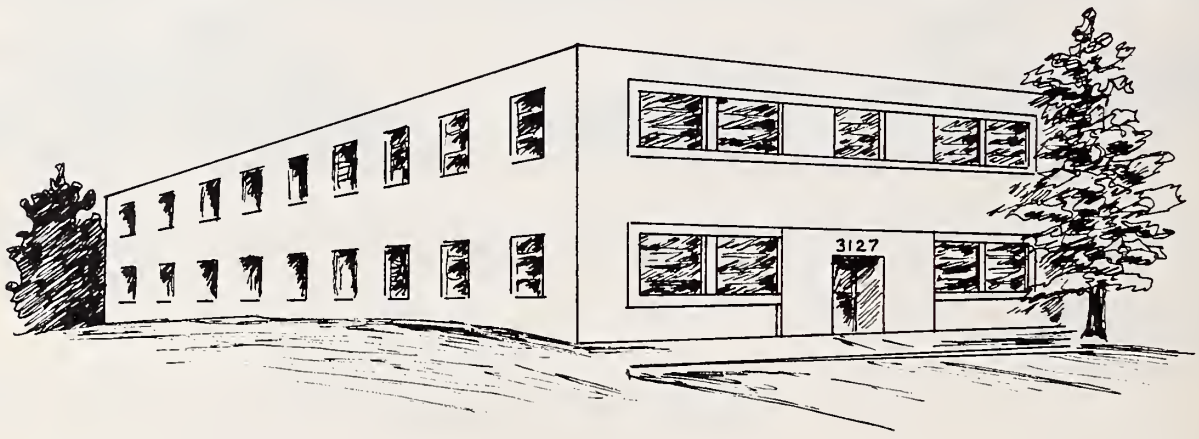
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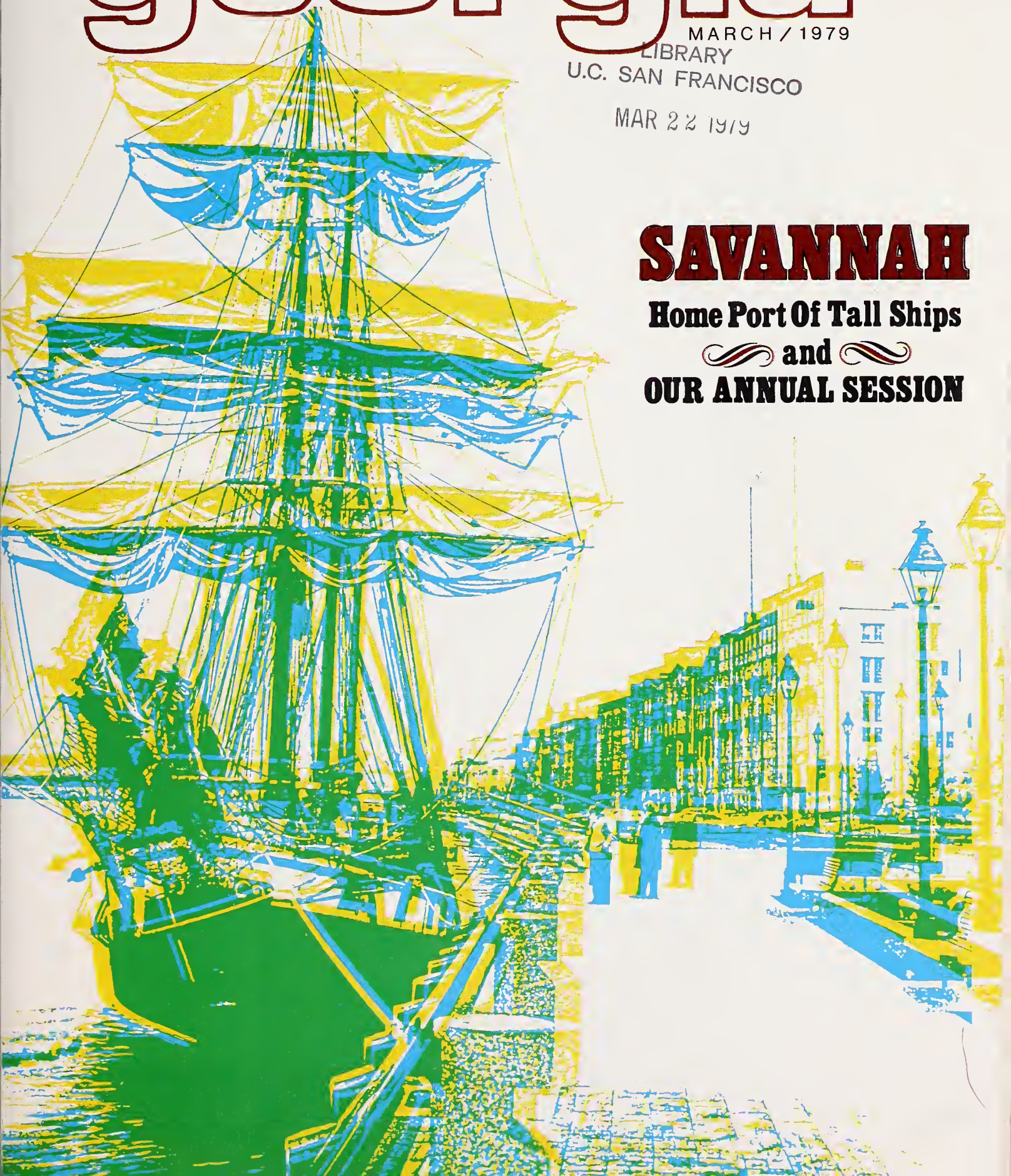
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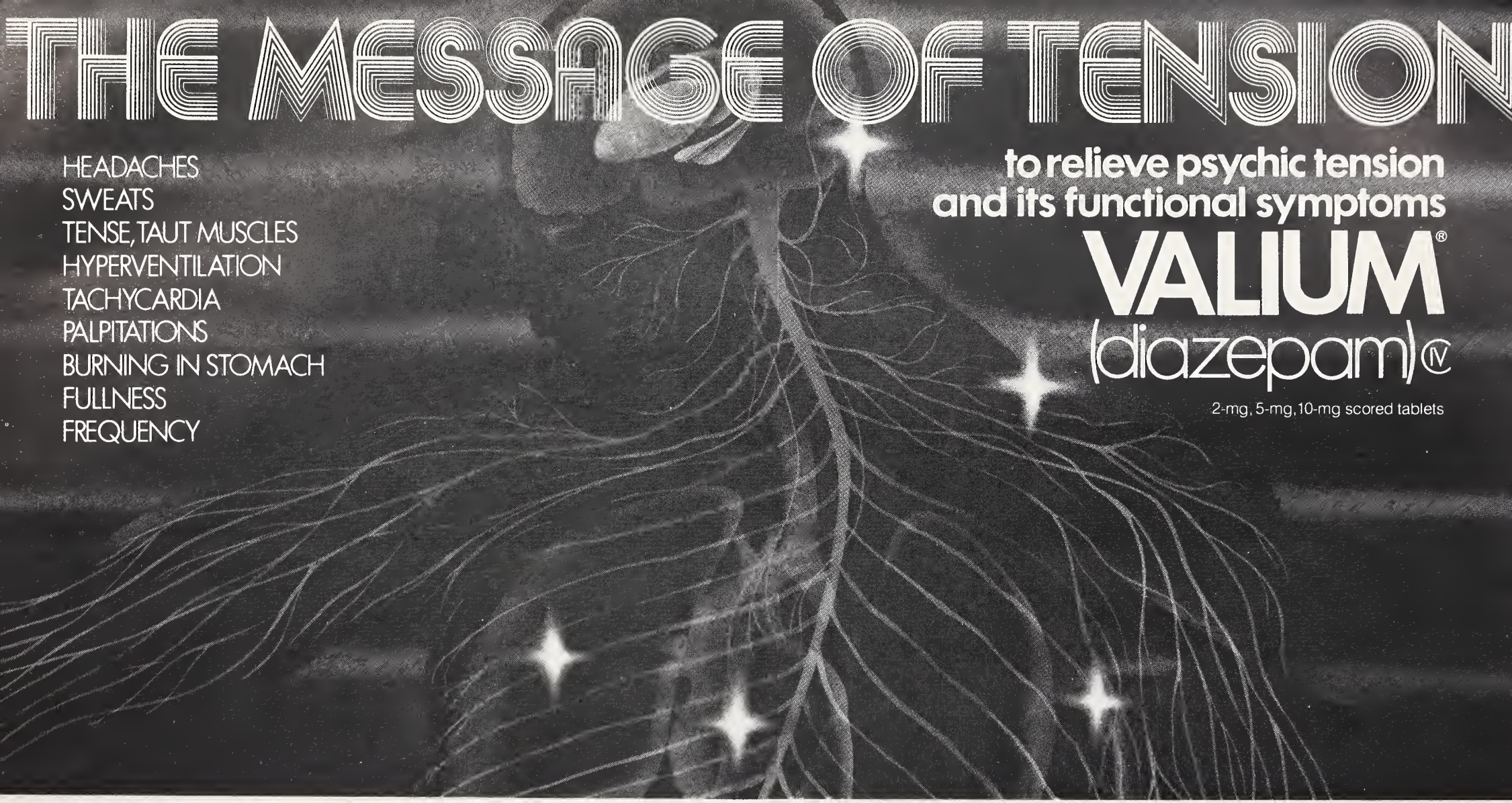
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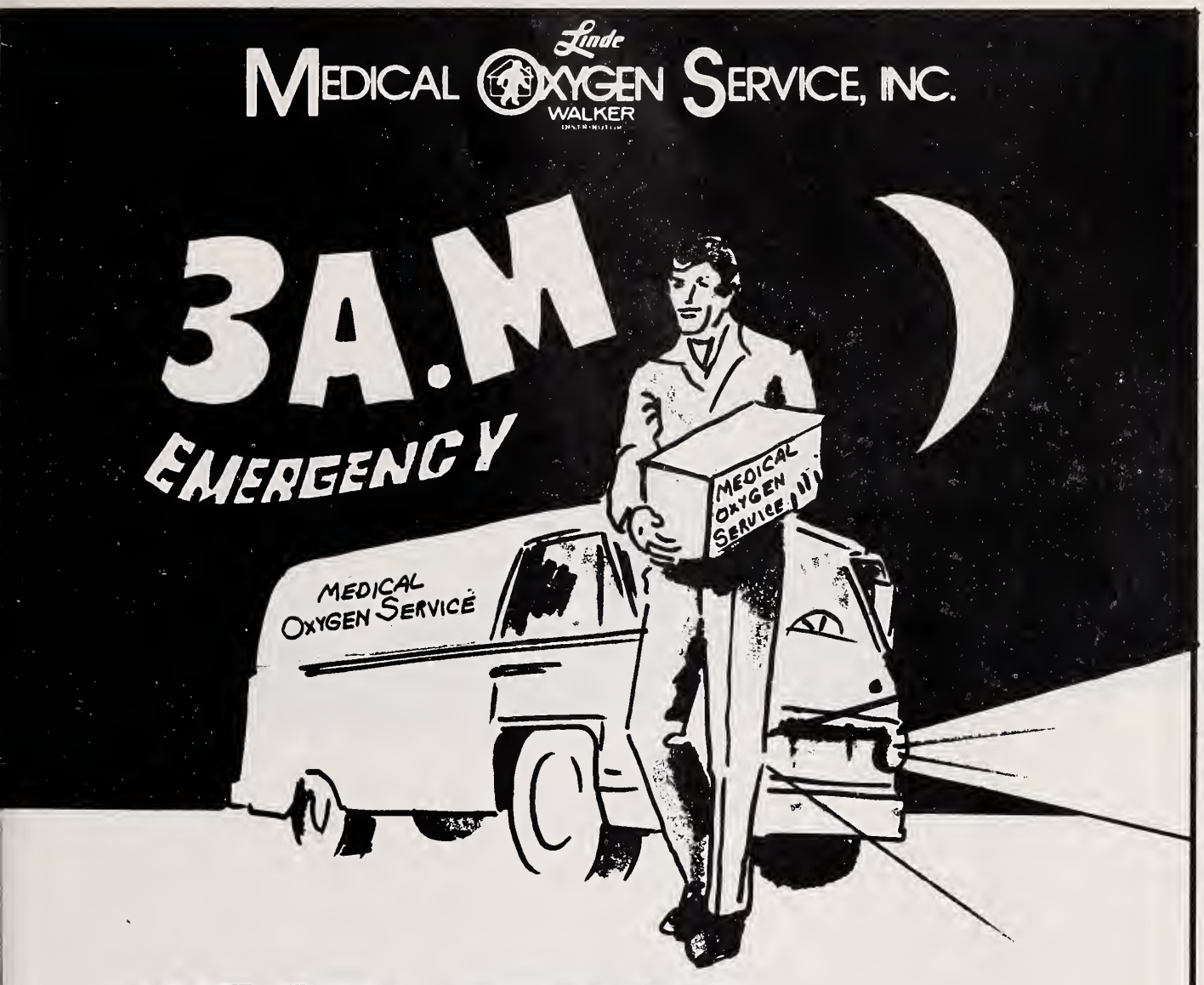
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THE COVER

As our cover suggests, Savannah is the place to be in April. Escape there and take part in our Annual Session. The design of tall ships was inspired by John Masefield's poem, "Sea-Fever," (on page 223) and colorfully interpreted by Richard Lyons.

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Letters to the Editor . . .

Where There's Smoke . . . Readers Respond

Dear Sir:

I am pleased to see MAG surveying physicians about smoking in medically oriented facilities. Unfortunately, MAG's position apparently has been so low key that most members have not known of it.

I think this is a most important endeavor and the accompanying material indicates some of my efforts in this regard.

Some years ago I wrote to the Medical Association of Atlanta and asked that consideration be given to this measure and nothing happened. Again, on 9 February 1978 I wrote to MAA and on 22 August 1978 they asked me to meet with the Board of Trustees and present the concept to them. To date nothing has happened.

As you can also see, the JAMA was more receptive and published my thoughts on the matter as a lead editorial in the 19 May 1978 issue.

I will be very interested in the results of your survey and would be pleased to work with the appropriate MAG committee if I may be of some assistance.

Sheldon B. Cohen, M.D.
Atlanta

Dear Sir:

It is alarming to note the amount of smoking presently being done in hospitals. Patients complain to me almost daily about being exposed to cigarettes in the hospital environment. I approached my hospital administrator concerning this and was told that following the JCAH guidelines concerning smoking in hospitals would create "too many complaints."

I feel there is a need for a State Law prohibiting smoking in hospitals and doctor's offices or, at the minimum, a law which would protect the innocent bystanders from the exposure to cigarette smoke.

Philip R. Saleeby, M.D.
Brunswick

Dear Sir:

Your memorandum of October 27 addressed to hospital administrators regarding the survey on the subject of smoking is an item of great interest and importance to me personally and to the medical facility of Wildwood Sanitarium & Hospital.

As you may not be aware, the entire staff of Wildwood Sanitarium & Hospital are members of the Seventh-day Adventist religious faith. One of the strongest areas of emphasis adhered to by Seventh-day Adventists is in the practice of health principles — which, of course, leaves no allowance for smoking and the deteriorating effects it has in the human body.

Smoking-related policies in our health facility have not changed, due to the fact that from the very onset of our medical program our entire focus has been on preventive medicine.

Truly, it is tragic in view of all the scientifically-confirmed hazards related to smoking that government and the public continue to argue the point that all the research and information rendered is basically inconclusive evidence. The real paradox in this issue was when, on August 5, 1978, President Carter stated that he saw no inconsistency in a $30 million federal anti-smoking campaign while the government continued to help tobacco farmers financially. He further stated:

"As long as I'm in the White House . . . we'll have a good tobacco program."

I question the validity of anyone's program when millions of dollars are spent on research, thousands of people are dying, man continues to practice measures detrimental to anyone's health — and yet, man continues to illusively hope that what we are witnessing is not reality.

Our concern at Wildwood Sanitarium & Hospital — a concern shared by many medical facilities in the country today — is the high cost of medical care. And yet, the hypocrisy that often surfaces (very aptly put by the old Indian proverb: "Talking with a split tongue") certainly does not render sound health practices.

Therefore, the initial focus at Wildwood Sanitarium & Hospital is on preventive medicine. Certainly, as implied by the wholistic approach to man's health, it is much better to do something before he is ill than to do something after he is a physical wreck.

Needless to say, from your viewpoint as a physician, I do not need to emphasize to you the impact that smoking has on the cardiac and respiratory areas of health.

If I can be of further assistance to you in this area, please do not hesitate to make inquiry.

Leo Vital, Administrator
Wildwood

MEDICAL MEETING CALENDAR

MARCH

26-28 — *Savannah;* **SELECTED TOPICS IN OPHTHALMOLOGY;** Contact: Division of Continuing Education, Medical College of Georgia, Augusta 30901. PH: 404/828-3967.

29-30 — *Atlanta;* **THE TREATMENT OF ARTHRITIS — UPDATE;** Category 1 credit; Contact: Associate Dean for CME, 69 Butler St., S.E., Atlanta 30303. PH: 404/588-3534.

30-31 — *Atlanta;* **FITNESS AND PREVENTIVE HEALTH;** Contact: John D. Cantwell, M.D., 229 Peachtree St., N.E., Atlanta 30303.

APRIL

2-4 — *Atlanta;* **INFECTIOUS DISEASE AND IMMUNOLOGY FOR THE PEDIATRICIAN;** Category 1 credit; Contact: Associate Dean for CME, 69 Butler St., S.E., Atlanta 30303. PH: 404/588-3534.

4-6 — *Augusta;* **CASE STUDIES IN CARDIOLOGY;** Category 1 credit; Contact: Division of Continuing Education, Medical College of Georgia, Augusta 30901. PH: 404/828-3967.

5-6 — *Atlanta;* **DERMATOLOGY POSTGRADUATE COURSE;** Category 1 credit; Contact: Associate Dean for CME, 69 Butler St., S.E., Atlanta 30303. PH: 404/588-3534.

5-6 — *Marietta;* **14TH ANNUAL COBB COUNTY SYMPOSIUM;** Contact: Kennesaw College, Box 444, Marietta 30061. PH: 404/422-8770.

6 — *Chattanooga, TN;* **ADVANCES IN THE DIAGNOSIS AND MANAGEMENT OF HYPERTENSION;** Category 1 credit; Contact: Dennis K. Wentz, M.D., UT Center for Health Sciences, 62 S. Dunlap St., Memphis, TN 38163.

6-7 — *Atlanta;* **ANNUAL MEETING OF THE SOUTHERN SOCIETY OF PHYSICAL MEDICINE AND REHABILITATION;** Contact: Robert Christopher, M.D., 800 Madison, Memphis, TN 38163. PH: 901/528-5500.

6-8 — *Atlanta;* **CORONARY DISEASE, EXERCISE TESTING, AND CARDIAC REHABILITATION;** Category 1 credit; Contact: International Medical Education Corporation, 64 Inverness Dr. East, Englewood, CO 80112. PH: 800/525-8646.

7-14 — *Caribbean Sea;* **INFECTIOUS DISEASE FOR THE CLINICIAN;** Contact: Dennis K. Wentz, M.D., UT Center for Health Sciences, 62 S. Dunlap St., Memphis, TN 38163. PH: 901/528-5605.

11-13 — *Atlanta;* **FIFTH ANNUAL COURSE ON TECHNIQUES IN ORTHOPEDIC SURGERY: RECONSTRUCTIVE SURGERY OF THE KNEE;** Category 1 credit; Contact: Associate Dean for CME, 69 Butler St., S.E., Atlanta 30303. PH: 404/588-3534.

12-14 — *Atlanta;* **PERSPECTIVES IN SURGERY;** Category 1 credit; Contact: Associate Dean for CME, 69 Butler St., S.E., Atlanta 30303. PH: 404/588-3534.

13, 14, 16-18 — *Atlanta;* **ROBERT P. KELLY MEMORIAL VISITING PROFESSOR, ROBERT LEACH, M.D.;** Contact: Robert P. Kelly Emory Orthopaedic Residency Alumni Association, 1365 Clifton Rd., N.E., Atlanta 30322. PH: 404/321-0111, ext. 349.

17-18 — *Augusta;* **NEONATOLOGY — THE SICK NEWBORN;** Category 1 credit; Contact: Division of Continuing Education, Medical College of Georgia, Augusta 30901. PH: 404/828-3967.

17-21 — *Atlanta;* **32ND ANNUAL MEETING OF THE SOCIETY OF SURGICAL ONCOLOGY;** Contact: John T. Godwin, M.D., 4691 Sentinel Post Rd., N.W., Atlanta 30327.

19-20 — *Atlanta;* **APPLYING SPACE-AGE TECHNOLOGY TO MEDICINE;** Category 1 credit; Contact: Associate Dean for CME, 69 Butler St., S.E., Atlanta 30303. PH: 404/588-3534.

19-20 — *Augusta;* **PREDICTIVE AND PREVENTIVE MEDICINE;** Contact: Division of Continuing Education, Medical College of Georgia, Augusta 30901. PH: 404/828-3967.

24-25 — *Atlanta;* **THE MANAGEMENT OF THE CHILD WHO DOES NOT GROW;** Contact: Institute of Pennsylvania Hospital, 111 N. 49th St., Philadelphia, PA 19139.

24-27 — *Atlanta;* **CLINICAL BIOFEEDBACK TRAINING COURSE, VI;** Contact: Dept. of Rehabilitation Medicine, 1441 Clifton Rd., N.E., Atlanta 30322. PH: 404/329-5507.

26-27 — *Chattanooga, TN;* **ORTHOPAEDICS;** Category 1 credit; Contact: Dennis K. Wentz, M.D., UT Center for Health Sciences, 62 S. Dunlap St., Memphis, TN 38163.

27 — *Atlanta;* **FIRST ANNUAL UPDATE — GASTROENTEROLOGY;** Category 1 credit; Contact: Office of CME, Georgia Baptist Medical Center, 300 Boulevard, N.E., Atlanta 30312. PH: 404/659-4221, ext. 2346.

27-28 — *Chapel Hill, NC;* **12TH MALIGNANT DISEASE SYMPOSIUM;** Contact: William Wood, M.D., Office of Continuing Education, 236 MacNider Bldg., 202-H, UNC School of Medicine, Chapel Hill, NC 27514.

30-May 2 — *Atlanta;* **PHARMACOLOGY FOR ANESTHESIOLOGISTS;** Category 1 credit; Contact: Associate Dean for CME, 69 Butler St., S.E., Atlanta 30303. PH: 404/588-3534.

MAY

4-6 — *Kiawah Island, SC;* **CURRENT CONCEPTS IN PEDIATRIC ORTHOPAEDIC SURGERY;** Category 1 credit; Contact: Associate Dean for CME, 69 Butler St., S.E., Atlanta 30303. PH: 404/588-3534.

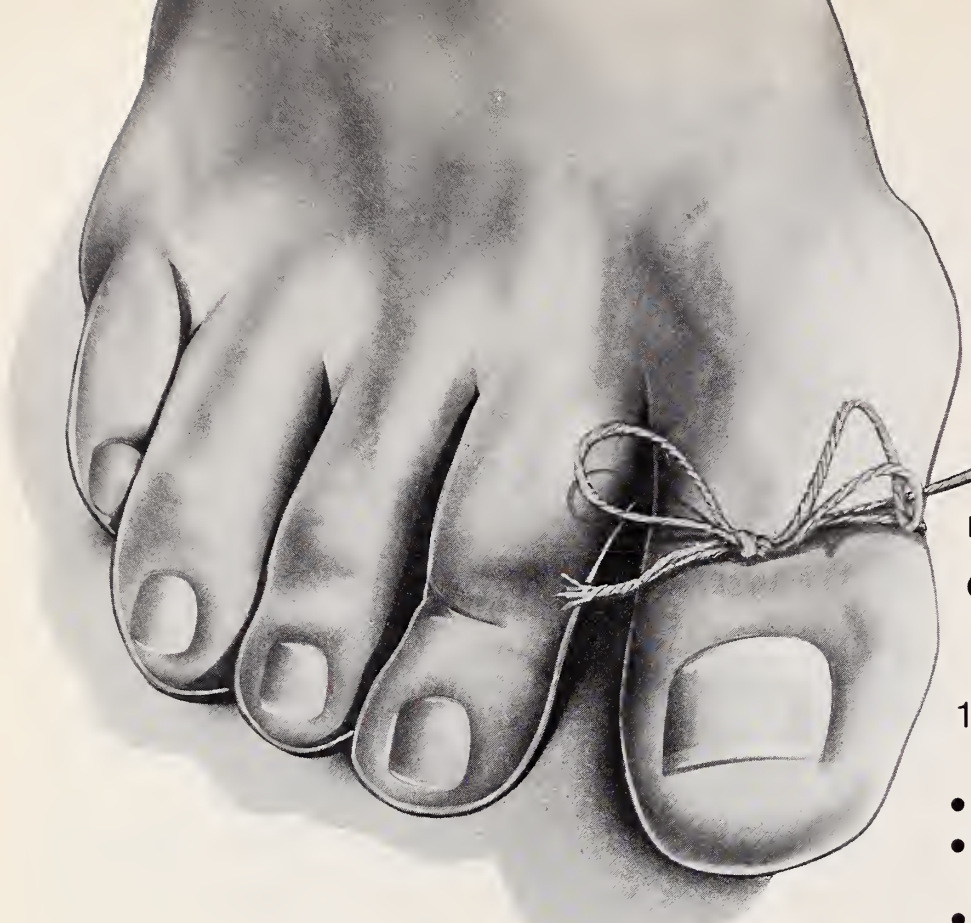
5-6 — *Atlanta;* **THE ADDICTED PATIENT: PRACTICAL APPROACHES TO TREATMENT;** Contact: Institute of Pennsylvania Hospital, 111 N. 49th St., Philadelphia, PA 19139.

19-20 — *Savannah;* **AMA REGIONAL MEETING;** Contact: G. K. Jewett, Dept. of Continuing Education Seminars, AMA, 535 N. Dearborn St., Chicago, IL 60610. PH: 312/751-6570.

24-26 — *Atlanta;* **CLINICAL TOPICS IN GYNECOLOGY AND OBSTETRICS;** Category 1 credit; Contact: Associate Dean for CME, 69 Butler St., S.E., Atlanta 30303. PH: 404/588-3534.

26-27 — *Atlanta;* **PRIVATE ENTERPRISE PERSPECTIVES ON MEDICINE;** Category 1 credit; Contact: Sue McAvoy, MAG, 938 Peachtree St., N.E., Atlanta 30309. PH: 404/876-7535.

For additional information on these and other meetings, contact MAG, Division of Education 404/876-7535.



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A few cases of reversible clinical hepatotoxicity have been noted and in some patients asymptomatic rises in serum alkaline phosphatase or serum transaminase have been observed. Accordingly, periodic liver function tests should be performed during the early stages of therapy, particularly in patients with pre-existing liver disease.

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Usage in Pregnancy and Women of Childbearing Age: Zyloprim® (allopurinol) should be used in pregnant women or women of childbearing age only if the potential benefits to the patient are weighed against the possible risk to the fetus.

PRECAUTIONS: Some investigators have reported an increase in acute attacks of gout during the early stages of allopurinol administration, even when normal or subnormal serum uric acid levels have been attained.

It has been reported that allopurinol prolongs the half-life of the anticoagulant, dicumarol. This interaction should be kept in mind when allopurinol is given to patients already on anticoagulant therapy, and the coagulation time should be reassessed.

A fluid intake sufficient to yield a daily urinary output of at least 2 liters and the maintenance of a neutral or, preferably, slightly alkaline urine are desirable to (1) avoid the theoretic possibility of formation of xanthine calculi under the influence of Zyloprim therapy and (2) help prevent renal precipitation of urates in patients receiving concomitant uricosuric agents.

Patients with impaired renal function require less drug and should be carefully observed during the early stages of Zyloprim administration and the drug withdrawn if increased abnormalities in renal function appear.

In patients with severely impaired renal function, or decreased urate clearance, the half-life of oxipurinol in the plasma is greatly prolonged. Therefore, a dose of 100 mg per day or 300 mg twice a week, or perhaps less, may be sufficient to maintain adequate xanthine oxidase inhibition to reduce serum urate levels. Such patients should be treated with the lowest effective dose, in order to minimize side effects.

Mild reticulocytosis has appeared in some patients.

As with all new agents, periodic determination of liver and kidney function and complete blood counts should be performed especially during the first few months of therapy.

ADVERSE REACTIONS:

Dermatologic: Because in some instances skin rash has been followed by severe hypersensitivity reactions, it is recommended that therapy be discontinued at the first sign of rash or other adverse reaction (see WARNINGS). Skin rash, usually maculopapular, is the adverse reaction most commonly reported.
Exfoliative, urticarial and purpuric lesions, Stevens-Johnson syndrome (erythema multiforme) and toxic epidermal necrolysis have also been reported.
A few cases of alopecia with and without accompanying dermatitis have been reported.
In some patients with a rash, restarting Zyloprim (allopurinol) therapy at lower doses has been accomplished without untoward incident.

Gastrointestinal: Nausea, vomiting, diarrhea, and intermittent abdominal pain have been reported.

Vascular: There have been rare instances of a generalized hypersensitivity vasculitis or necrotizing angiitis which have led to irreversible hepatotoxicity and death.

Hematopoietic: Agranulocytosis, anemia, aplastic anemia, bone marrow depression, leukopenia, pancytopenia and thrombocytopenia have been reported in patients, most of whom received concomitant drugs with potential for causing these reactions. Zyloprim® (allopurinol) has been neither implicated nor excluded as a cause of these reactions.

Neurologic: There have been a few reports of peripheral neuritis occurring while patients were taking Zyloprim. Drowsiness has also been reported in a few patients.

Ophthalmic. There have been a few reports of cataracts found in patients receiving Zyloprim. It is not known if the cataracts predated the Zyloprim therapy. "Toxic" cataracts were reported in one patient who also received an anti-inflammatory agent; again, the time of onset is unknown. In a group of patients followed by Gutman and Yü for up to five years on Zyloprim therapy, no evidence of ophthalmologic effect attributable to Zyloprim was reported.

Drug Idiosyncrasy: Symptoms suggestive of drug idiosyncrasy have been reported in a few patients. This was characterized by fever, chills, leukopenia or leukocytosis, eosinophilia, arthralgias, skin rash, pruritus, nausea and vomiting.

OVERDOSAGE: Massive overdosing, or acute poisoning, by Zyloprim has not been reported.

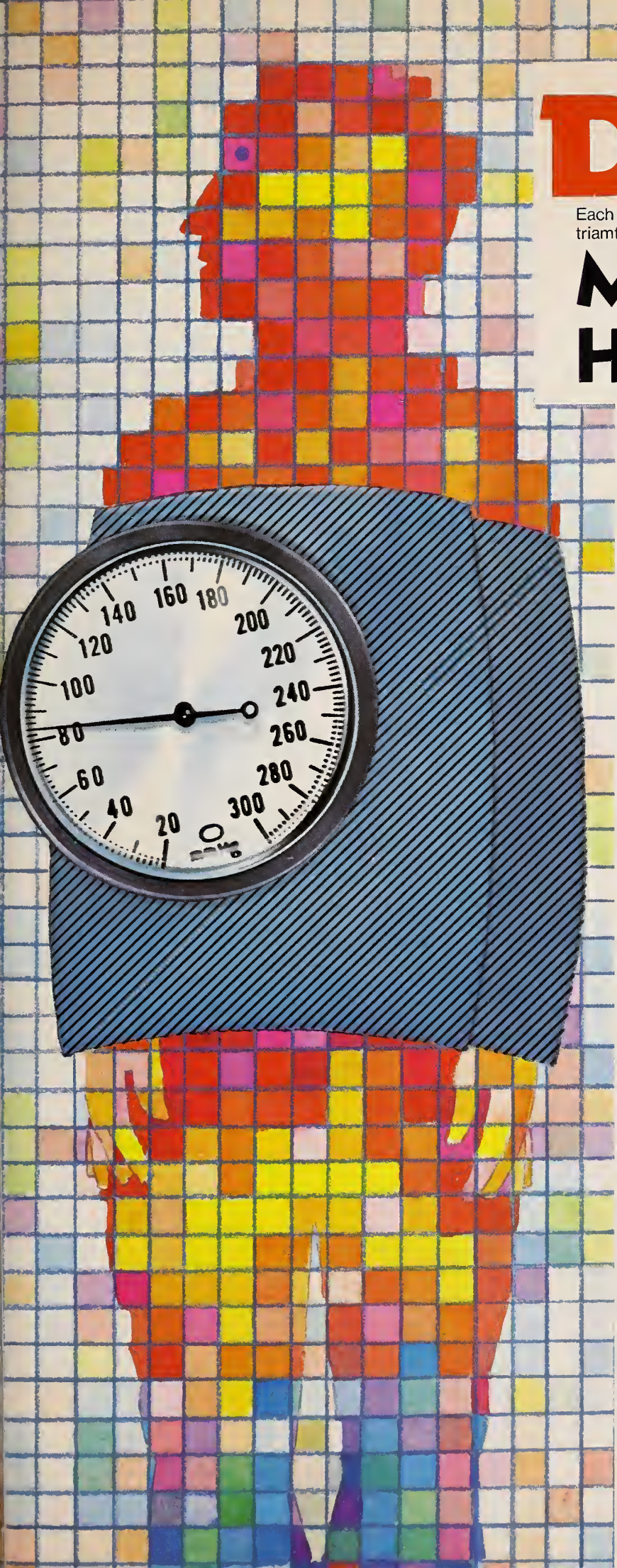
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Before prescribing, see complete prescribing information in SK&F Co. literature or *PDR*. A brief summary follows:

* **Warning**
This drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual. If this combination represents the dosage so determined, its use may be more convenient in patient management. Treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

Contraindications: Further use in anuria, progressive renal or hepatic dysfunction, hyperkalemia. Pre-existing elevated serum potassium. Hypersensitivity to either component or other sulfonamide-derived drugs.

Warnings: Do not use potassium supplements, dietary or otherwise, unless hypokalemia develops or dietary intake of potassium is markedly impaired. If supplementary potassium is needed, potassium tablets should not be used. Hyperkalemia can occur, and has been associated with cardiac irregularities. It is more likely in the severely ill, with urine volume less than one liter/day, the elderly and diabetics with suspected or confirmed renal insufficiency. Periodically, serum K+ levels should be determined. If hyperkalemia develops, substitute a thiazide alone, restrict K+ intake. **Associated widened QRS complex or arrhythmia requires prompt additional therapy.** Thiazides cross the placental barrier and appear in cord blood. Use in pregnancy requires weighing anticipated benefits against possible hazards, including fetal or neonatal jaundice, thrombocytopenia, other adverse reactions seen in adults. Thiazides appear and triamterene may appear in breast milk. If their use is essential, the patient should stop nursing. Adequate information on use in children is not available.

Precautions: Do periodic serum electrolyte determinations (particularly important in patients vomiting excessively or receiving parenteral fluids). Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics or those with suspected or confirmed renal insufficiency. Watch for signs of impending coma in severe liver disease. If spironolactone is used concomitantly, determine serum K+ frequently; both can cause K+ retention and elevated serum K+. Two deaths have been reported with such concomitant therapy (in one, recommended dosage was exceeded, in the other serum electrolytes were not properly monitored). Observe regularly for possible blood dyscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving triamterene, and leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with thiazides. Triamterene is a weak folic acid antagonist. Do periodic blood studies in cirrhotics with splenomegaly. Antihypertensive effect may be enhanced in post-sympathectomy patients. Use cautiously in surgical patients. The following may occur: transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), hyperuricemia and gout, digitalis intoxication (in hypokalemia), decreasing alkali reserve with possible metabolic acidosis. 'Dyazide' interferes with fluorescent measurement of quinidine.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis, rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting, diarrhea, constipation, other gastrointestinal disturbances. Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and, rarely, allergic pneumonitis have occurred with thiazides alone.

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helps control abnormal motor activity with minimal anticholinergic side effects†

Demonstrated smooth muscle relaxant activity.

In this double-blind study, twenty patients having G.I. series and exhibiting spasm were randomly selected to receive either 2 cc. of Bentyl or sodium chloride intramuscularly. Ten minutes after the injection another radiograph was taken . . .

. . . Bentyl produced definite relaxation in 8 of 10 patients. The sodium chloride produced relaxation in only 3 of 10. No side effects occurred in either group of patients.



Pylorospasm has almost totally blocked passage of barium meal.



Barium meal beginning to pass 10 minutes after intramuscular injection of 20 mg. Bentyl.

"The correlation of spasm relief and drug given was excellent."

*This drug has been classified "probably" effective in treating functional bowel/irritable bowel syndrome.

†See Warnings, Precautions and Adverse Reactions.

See following page for prescribing information.

Reference:
King, J.C. and Starkman, N.M.: Evaluation of an antispasmodic. Double-blind evaluation to control gastrointestinal spasms occurring during radiographic examination. A preliminary report. Western Med. 5:356-358, 1964.

Merrell

8-4420 (Y736A) MNR-804

Bentyl®

(dicyclomine hydrochloride USP)

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Brief Summary

INOICATIONS

Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FOA has classified the following indications as "probably" effective:

For the treatment of functional bowel/irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis.

THESE FUNCTIONAL OISOROERS ARE OFTEN RELIEVED BY VARYING COMBINATIONS OF SEOATIVE, REASSURANCE, PHYSICIAN INTEREST, AMELIORATION OF ENVIRONMENTAL FACTORS.

For use in the treatment of infant colic (syrup).

Final classification of the less-than-effective indications requires further investigation.

CONTRAINOICATIONS: Obstructive uropathy (for example, bladder neck obstruction due to prostatic hypertrophy); obstructive disease of the gastrointestinal tract (as in achalasia, pyloroduodenal stenosis); paralytic ileus, intestinal atony of the elderly or debilitated patient; unstable cardiovascular status in acute hemorrhage; severe ulcerative colitis; toxic megacolon complicating ulcerative colitis; myasthenia gravis. WARNINGS: In the presence of a high environmental temperature, heat prostration can occur with drug use (fever and heat stroke due to decreased sweating). Oiarrhea may be an early symptom of incomplete intestinal obstruction, especially in patients with ileostomy or colostomy. In this instance treatment with this drug would be inappropriate and possibly harmful. Bentyl may produce drowsiness or blurred vision. In this event, the patient should be warned not to engage in activities requiring mental alertness such as operating a motor vehicle or other machinery or perform hazardous work while taking this drug. PRECAUTIONS: Although studies have failed to demonstrate adverse effects of dicyclomine hydrochloride in glaucoma or in patients with prostatic hypertrophy, it should be prescribed with caution in patients known to have or suspected of having glaucoma or prostatic hypertrophy. Use with caution in patients with: Autonomic neuropathy. Hepatic or renal disease. Ulcerative colitis. Large doses may suppress intestinal motility to the point of producing a paralytic ileus and the use of this drug may precipitate or aggravate the serious complication of toxic megacolon. Hyperthyroidism, coronary heart disease, congestive heart failure, cardiac arrhythmias, and hypertension. Hiatal hernia associated with reflux esophagitis since anticholinergic drugs may aggravate this condition.

Do not rely on the use of the drug in the presence of complication of biliary tract disease. Investigate any tachycardia before giving anticholinergic (atropine-like) drugs since they may increase the heart rate. With overdosage, a curare-like action may occur. AOVERSE REACTIONS: Anticholinergics/antispasmodics produce certain effects which may be physiologic or toxic depending upon the individual patient's response. The physician must delineate these. Adverse reactions may include xerostomia; urinary hesitancy and retention; blurred vision and tachycardia; palpitations; mydriasis; cycloplegia; increased ocular tension; loss of taste; headache; nervousness; drowsiness; weakness; dizziness; insomnia; nausea; vomiting; impotence; suppression of lactation; constipation; bloated feeling; severe allergic reaction or drug idiosyncrasies including anaphylaxis; urticaria and other dermal manifestations; some degree of mental confusion and/or excitement, especially in elderly persons; and decreased sweating. With the injectable form there may be a temporary sensation of lightheadedness and occasionally local irritation. OOSAGE ANO AOMINISTRATION: Oosage must be adjusted to individual patient's needs.

Usual Dosage: Bentyl 10 mg. capsule and syrup: *Adults:* 1 or 2 capsules or teaspoonfuls syrup three or four times daily. *Children:* 1 capsule or teaspoonful syrup three or four times daily. *Infants:* ½ teaspoonful syrup three or four times daily. (May be diluted with equal volume of water.) Bentyl 20 mg.: *Adults:* 1 tablet three or four times daily. Bentyl Injection: *Adults:* 2 ml. (20 mg.) every four to six hours intramuscularly only. NOT FOR INTRAVENOUS USE. MANAGEMENT OF OVEROOSE: The signs and symptoms of overdose are headache, nausea, vomiting, blurred vision, dilated pupils, hot, dry skin, dizziness, dryness of the mouth, difficulty in swallowing, CNS stimulation. Treatment should consist of gastric lavage, emetics, and activated charcoal. Barbiturates may be used either orally or intramuscularly for sedation but they should not be used if Bentyl with Phenobarbital has been ingested. If indicated, parenteral cholinergic agents such as Urecholine® (bethanecol chloride USP) should be used.

Product Information as of October, 1978.

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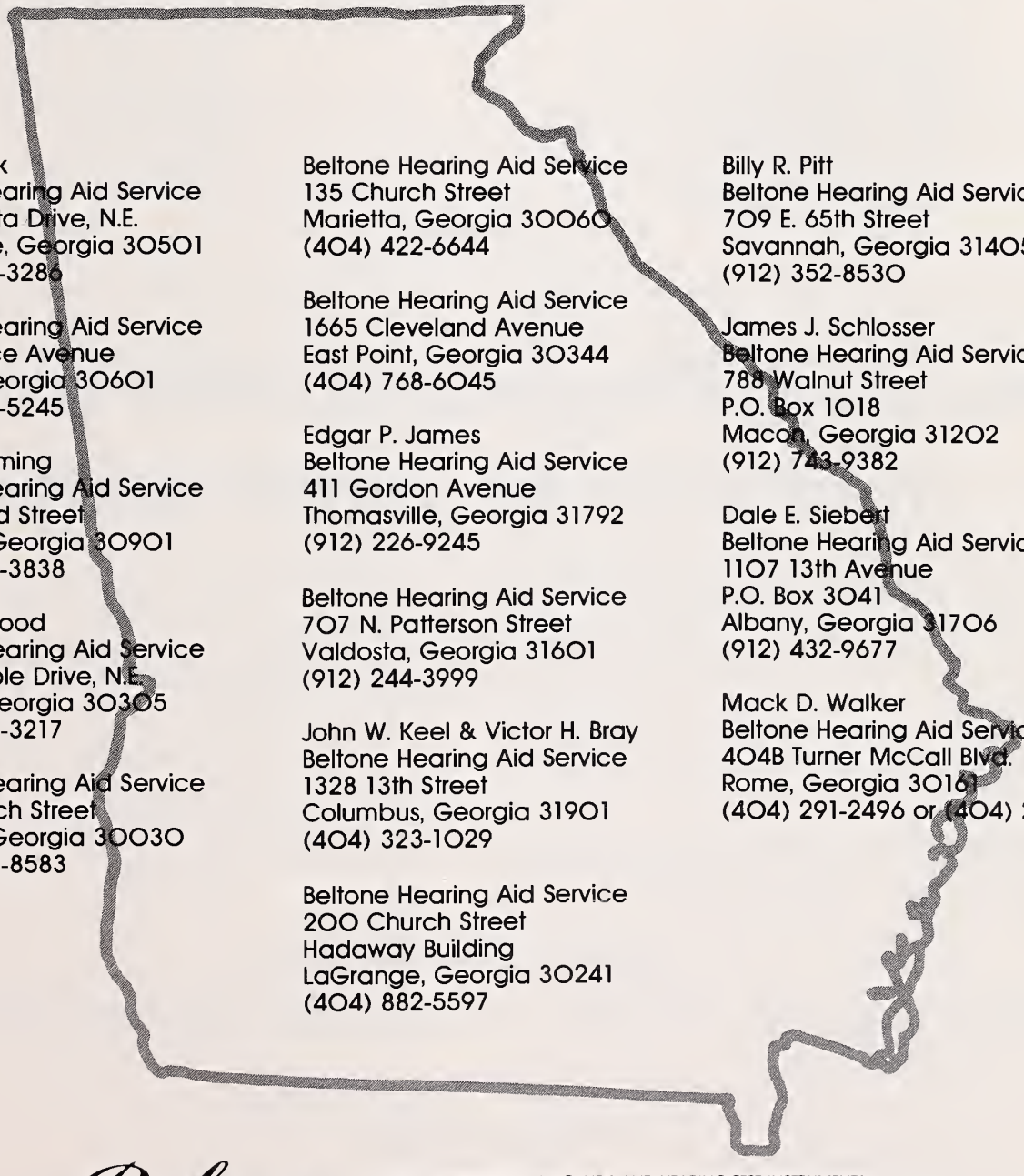
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Highlights of the 1979 Surgeon General's Report on Smoking and Health*

In the 15 years that have elapsed since the original Report of the Advisory Committee on Smoking and Health to the Surgeon General, there have been many new scientific studies on the relationship between tobacco consumption and health. There are now more than 30,000 articles in the world literature on this subject. The new volume on smoking and health includes a detailed review and update of the relationships between smoking and health written by various agencies within the U.S. Department of Health, Education, and Welfare, and coordinated and assembled by the Office on Smoking and Health. This is a summary of selected chapters in the new 1979 Surgeon General's Report. The complete edition of the report, when available in Spring 1979, may be requested from the Office on Smoking and Health, Park Bldg., Rm. 158, Rockville, Md. 20857.

Smoke and Physiology: The lighted cigarette generates about 4,000 compounds which can be separated into gas and particulate phases. Carbon monoxide (CO) (the gas phase), nicotine, and tar (the particulate phase) are the most likely contributors to the health hazards of smoking. Many other compounds are probable or suspected contributors.

It is generally accepted that nicotine is principally responsible for cigarette smokers' physiologic responses through release of catecholamines, epinephrine, and norepinephrine. Short-term physiologic responses attributable to nicotine and/or catecholamines include increased heart rate, blood pressure, cardiac output, stroke volume, oxygen consumption, coronary blood flow, and arrhythmias. Bronchoconstriction and related pulmonary manifestations, increased mobilization and utilization of free fatty acids, and hyperglycemic effects also occur.

Smoking enhances the breakdown of drugs by increasing the amount and the activity of hepatic microsomal enzymes. Some therapeutic agents whose clinical effects are modified by smoking are phenacetin, antipyrine, theophylline, caffeine, imipramine, pentazocine, and vitamin C.

Tobacco smoking also affects the values of a number of clinical laboratory tests in humans. Such changes include increases in the number of leukocytes, the red cell mass, the levels of hemoglobin and carboxyhemoglobin, and the hematocrit. Cigarette smoking decreases the serum levels of creatinine, albumin, globulin (in females) and uric acid (in males). These levels revert to normal after cessation of smoking.

Mortality: Data from the seven original prospective studies, from long-term follow-up of three of these studies, and from prospective studies in Japan and Sweden yield quantitative results substantially identical to earlier conclusions. Overall, current cigarette smokers have an approximately 70% greater chance of dying from disease than nonsmokers (i.e., smokers have an overall mortality ratio of 1.7; see Table 1). Specific mortality ratios are directly proportional to the amount smoked and to the years of cigarette smoking, and are higher both for those who initiated their smoking at younger ages and for those who inhale. Although mortality ratios for smokers are highest at the younger ages and decline with increasing age, the actual number of excess deaths attributable to cigarette smoking increases with age.

* Reported by the Office on Smoking and Health, U.S. Department of Health, Education, and Welfare, Office of the Assistant Secretary for Health. Reprinted from the January 12, 1979, issue of *The Morbidity and Mortality Weekly Report*, published by the Center for Disease Control in Atlanta.

Former cigarette smokers experience declining mortality ratios as the years of not smoking increase. After 15 years, mortality ratios for former smokers approach those for individuals who never smoked. Mortality ratios for any given age for former smokers are directly proportional to the amount smoked before cessation and inversely related to the age of smoking initiation. Regardless of these factors, cessation does diminish an individual's risk, provided s/he is not ill at the time of cessation. Overall mortality ratios for female smokers are somewhat less than those for male smokers. However, subsets of females with smoking characteristics similar to those of men experience mortality rates similar to those of male smokers.

Calculations from prospective study data have indicated that life expectancy at any given age is significantly shortened by cigarette smoking. However, mortality ratios are decreased in smokers who use cigarettes with a decreased tar and nicotine content. From the detailed data of two prospective studies, excess mortality is found to be greatest for the 45- to 54-year age group among women and men, indicating that smoking causes premature mortality. Coronary heart disease is the chief contributor to the excess mortality among cigarette smokers, followed by lung cancer and chronic obstructive lung disease.

Individuals who limit their smoking to only pipes and cigars have overall mortality rates that are slightly higher than nonsmokers, but lower than cigarette smokers.

Morbidity: Following the 1964 Report to the Surgeon General, the National Center for Health Statistics began collecting information on smoking, on the basis of probability samples of the population, as part of the National Health Interview Survey. These data have proven valuable in assessing the relationships between tobacco use and health indicators including illness and disability.

In general, male and female current cigarette smokers report more acute and chronic conditions than persons who never smoked. The age-adjusted incidence of acute conditions for males who had ever smoked was 14% higher, and for females 21% higher, than for those who had never smoked cigarettes. Non-physician-dependent indicators of morbidity include measures such as work-days lost, days in bed, and limitation of activity resulting from chronic disease. As derived from 1974 survey data, there are more than 81,000,000 excess work days lost and more than 145,000,000 excess days of bed disability per year due to smoking in the U.S. population. Current and former smokers also reported more hospitalizations in the year prior to interview than did non-smokers. Data on disability and illness often show continued higher risk among former smokers, although these data are not conclusive.

Cardiovascular Disease: Systematic observations on the association between cardiovascular disease and smoking have been made on considerably more than 1 million individuals (mostly men) in the United States, and have involved many millions of person-years of experience. Sample sizes are now extensive in both retrospective and prospective studies, and it can be concluded that smoking is causally related to coronary heart disease for both men and women in the United States.

The data show that smoking is one of three major, independent risk factors for heart attack. The effect is dose-related (including a lower risk with low tar and nicotine cigarettes), synergistic with other risk factors for heart attack, and more strongly associated with younger ages. Smoking also increases the possibility of recurrence of myocardial infarction. Cessation of smoking reduces the risk of mortality from coronary heart disease, and after 10 years of not smoking cigarettes this risk approaches that of the non-smoker.

Smoking is a major risk factor for arteriosclerotic peripheral vascular disease and is associated with more severe and extensive atherosclerosis of the aorta and coronary arteries than is found among nonsmokers. In persons with angina pectoris or with intermittent claudication of peripheral vascular disease, smoking reduces the individual's established threshold for the precipitation of angina or claudication. Although it does not induce chronic hypertension, cigarette smoking in the presence of hypertension acts synergistically to increase the effective risk for coronary heart disease. Women who smoke and use oral contraceptives are at a significantly elevated risk of fatal and non-fatal myocardial infarction. The relationship of smoking to the incidence of stroke is not established; however, an association with subarachnoid hemorrhage has been reported in women.

Cancer: The most definite causal relationship between tobacco use and any disease was shown in the 1950s and 1960s with lung cancer. Since then, additional studies have strengthened the earlier conclusions, particularly with regard to women smokers for whom only preliminary data were then available. Lung cancer mortality rates in women are increasing more rapidly than in men, and if present trends continue, this disease will be the leading cause of cancer deaths in women in the next decade.

Use of filter cigarettes and low tar and nicotine cigarettes decreases lung cancer mortality rates among smokers, although not to the low rates for

nonsmokers. Exsmokers experience decreasing lung cancer mortality rates which approach the rates of nonsmokers after 10 to 15 years of cessation.

Evidence has accumulated about the relationships between tobacco use and cancer of the larynx, oral cavity, esophagus, bladder, kidney, and pancreas. Cigarette smoking is a significant causative factor in laryngeal, oral, and esophageal cancers, as well as in lung cancer, and in all of these there is a dose-response effect. For each of these cancers there also appears to be a synergistic effect between smoking and alcohol intake. Pipe and cigar smokers experience approximately the same risk as cigarette smokers for all of these cancers, except lung cancer.

Epidemiologic studies have demonstrated a significant association between cigarette smoking and bladder cancer in both men and women, with smoking acting both independently and synergistically with other factors to increase the risk of developing bladder cancer. Cigarette smoking is also associated with cancer of the kidney in men (mortality ratio of 1.5) (Table 1), and with cancer of the pancreas.

Non-Neoplastic Bronchopulmonary Disease: Both female and male cigarette smokers have a significantly higher prevalence of chronic bronchitis and emphysema than nonsmokers, and they have an increased chance of dying from these diseases. Smokers, including teenagers who smoke, also have more respiratory symptoms, and at least some of these symptoms are dose-related. Pulmonary function abnormalities are greater among cigarette smokers than nonsmokers, with impairment of pulmonary function detectable even among smokers in young age groups. Cessation of smoking improves pulmonary function, and decreases the prevalence of respiratory symptoms as well as the chance of premature death from non-neoplastic bronchopulmonary disease. Autopsy data have demonstrated dose-related abnormalities in macroscopic and microscopic lung sections among smokers.

Interaction With Occupational Exposures: Significant excess lung cancer mortality has been noted for chromate, nickel, coal gas, and asbestos workers and for uranium miners; exposures to arsenic, hematite, beryllium, and copper are suspect. However, as noted in the 1964 Report, only a small part of the smoking population is exposed to industrial carcinogens, and these agents cannot account for the rising lung cancer risk in the general population. Unfortunately, few studies of occupational hazards include smoking histories, and therefore smoking, as a contributory or etiologic factor, cannot be fully evaluated.

Six ways have been identified in which smoking and physical and chemical agents in the workplace interact to produce or increase adverse health effects. Tobacco products may serve as vehicles for toxic agents, thus facilitating bodily entry by the agents. Work-place chemicals can be transformed into more harmful agents by smoking. Certain toxic agents in tobacco products and/or smoke can also be present in the workplace (CO, for example), thus increasing exposure to the agent. Or, smoking can cause an effect comparable to that which results from a toxic agent and thus cause an additive biologic effect. Alternatively, smoking can act synergistically with toxic agents, as is known to be the case with asbestos. Finally, smoking contributes to accidents in the workplace.

Those who have the highest risk of occupational exposure to toxic agents in general also have the highest smoking rates. Surveys have shown that male, blue-collar workers are much more likely to smoke than white-collar workers.

Pregnancy and Infant Health: Birth weight and fetal growth are significantly affected by smoking during pregnancy. Babies born to women who smoke during pregnancy are on the average 200 grams (g) lighter than babies born to comparable women who do not smoke. Twice as many of these babies weigh less than 2,500 g compared with babies of nonsmokers. Strong evidence indicates that this reflects the fetal growth rate, since there is no overall reduction in the duration of gestation when the mother smokes. The ratio of placental weight to birth weight increases with increasing levels of maternal smoking, possibly as a compensatory mechanism for the reduced oxygen availability due to carbon monoxide.

Epidemiologic studies do not provide conclusive data on the effect of maternal smoking on adequacy of lactation, although some animal studies reveal diminished milk production following administration of nicotine. A direct dose-response relationship does exist between the number of cigarettes smoked and the level of nicotine in breast milk.

Accumulated evidence does not indicate that maternal smoking increases the incidence of congenital malformations.

Peptic Ulcer Disease: Six studies have shown a greater prevalence of peptic ulcer disease among male cigarette smokers than among nonsmokers, the median ratio being 1.7 (i.e., their risk is increased by 70%); findings are comparable in women. There is a positive dose-response relationship between smoking and the incidence of peptic ulcer disease, and the risk of dying from peptic ulcer disease is, on the average, twice as high for smokers as for nonsmokers.

TABLE 1
MORTALITY RATIOS OF CURRENT CIGARETTE-ONLY SMOKERS, BY CAUSE OF DEATH, IN 8 PROSPECTIVE EPIDEMIOLOGIC STUDIES*

	STUDY									
	A	B		C	D	E	F	G		H
		Age in Years						Sex		
		45-64	65-79					M	F	
All cancers		2.14	1.76	2.21	1.62		1.97			
lung and bronchus	14.0	7.84	11.59	12.14	3.64	14.2	10.73	7.0	4.5	15.9
larynx		6.09	8.99	9.95	13.59		13.10			
buccal cavity	13.0	{ 9.90	{ 2.93	4.09	7.04	3.9	2.80			1.0
pharynx				12.54	2.81					
esophagus	4.7	4.17	1.74	6.17	2.57	3.3	6.60			0.7
bladder and other	2.1	2.20	2.96	2.15	0.98	1.3	2.40	1.8	1.6	6.0
pancreas	1.6	2.69	2.17	1.84	1.83	2.1		3.1	2.5	
kidney		1.42	1.57	1.45	1.11	1.4	1.50			
stomach		1.42	1.26	1.60	1.51	1.9	2.30	0.9	2.3	0.8
intestines		{ 1.01	{ 1.17	1.27	1.27	1.4	0.50			0.9
rectum	2.7			0.98	0.91	0.6	0.80			1.0
All cardiovascular		1.90	1.31	1.75			1.57			
coronary heart disease	1.6	2.03	1.36	1.74	1.96	1.6	1.70	1.7	1.3	2.0
cerebrovascular lesions	1.3	1.38	1.06	1.52	1.14	0.9	1.30	1.0	1.1	1.8
aortic aneurysm (non-syphilitic)	6.6	2.62	4.92	5.24		1.8		1.6		
hypertension		1.40	1.42	1.67	2.51	1.6	1.20	1.3	1.4	1.0
general arteriosclerosis	1.4			1.86		3.3	2.00	2.0	2.0	
All respiratory diseases (non-neoplastic)							2.85			
emphysema and/or bronchitis	24.7			10.08			2.30	1.6	2.2	4.3
emphysema without bronchitis		6.55	11.41	14.17		7.7				
bronchitis				4.49		11.3				
respiratory tuberculosis	5.0			2.12	1.27					
asthma				3.47						
influenza and pneumonia	1.4	1.86	1.72	1.87		1.4	2.60			2.4
Certain other conditions										
stomach ulcer	{ 2.5	4.06	4.13	4.13	{ 2.06					
duodenal ulcer		2.86	1.50	2.98		6.9	2.16			0.5
cirrhosis	3.0	2.06	1.97	3.33	1.35	2.3	1.93	2.4	0.8	4.0
parkinsonism	0.4			0.26						
All causes	1.64	1.88	1.43	1.84	1.22	1.52	1.70	1.4	1.2	1.78

* Study A: Doll R, Peto R: Mortality in relation to smoking: 20 years' observation on male British doctors. Br Med J 2:1525-1536, 1976; Study B: Hammond EC: Smoking in relation to the death rates of one million men and women, in Haenszel W (ed): Epidemiological Approaches to the Study of Cancer and Other Chronic Diseases. U.S. Public Health Service, National Cancer Institute Monograph 19, 1966, pp. 127-204; Study C: Kahn HA: The Dorn study of smoking and mortality among U.S. veterans: Report on 8½ years of observation, in Haenszel, *Ibid,* pp. 1-125; Study D: Hirayama T: Smoking in relation to the death rates of 265,118 men and women in Japan. A report on 5 years of follow-up. Presented at the American Cancer Society's 14th Science Writers' Seminar, Clearwater Beach, Florida, 24-29 Mar 1972; Study E: Best EWR: A Canadian study of smoking and health. Ottawa, Dept. of National Health and Welfare, 1966; Study F: Hammond EC, Horn D: Smoking and death rates — Report on forty-four months of follow-up on 187,783 men. I. Total mortality. II. Death rates by cause. JAMA 166:1159-1172, 1294-1308, 1958; Study G: Cederlof R, Friberg L, Hrubec Z, et al: The relationship of smoking and some social covariables to mortality and cancer morbidity. A ten-year follow-up in a probability sample of 55,000 Swedish subjects age 18-69. Part 1/2, Sweden. Karolinska Institute, 1975; Study H: Weir JM, Dunn JE, Jr.: Smoking and mortality: A prospective study. Cancer 25:105-112, 1970.

Allergy: Tobacco and tobacco smoke extracts have been found to act as antigens and to sensitize T-lymphocytes. However, the precise role of tobacco in immune and allergic processes cannot yet be delineated. Tobacco smoke does exert a variety of effects on respiratory tract structures; chronic smoking leads to consistent histologic changes in the respiratory tract including an adverse long-term effect on the mucociliary transport mechanisms and mucus composition, and morphologic and physiologic changes in macrophages. Alterations in cell-mediated immunity are noted locally and systemically in smokers.

Behavioral Aspects: There is some evidence that the smoking patterns of chronic smokers may be dependent on the nicotine content of their cigarettes. It is noted that the biologic half-life of nicotine in the human body is approximately 20-30 minutes and that regular smokers commonly consume 1 cigarette every 30-40 minutes, possibly in an attempt to maintain a constant nicotine level in the blood.

Abrupt and total withdrawal from tobacco is associated with symptoms that subside more quickly and are no worse than those seen in partial abstinence. There is fragmentary evidence suggesting that the abstinence syndrome is more severe in women than in men.

TABLE 2
ESTIMATES OF THE PERCENTAGE OF CURRENT, REGULAR CIGARETTE SMOKERS, ADULTS, UNITED STATES, 1964-1978

Year	Health Interview Survey (17 yrs. and over) Total	Male	Female	National Clearinghouse for Smoking & Health (21 yrs. and over) Total	Male	Female
1964				40.3	52.9	31.5
1965	41.7	51.1	33.3			
1966				42.2	51.9	31.7
1967						
1968						
1969						
1970	36.9	43.5	31.1	36.2	42.3	30.5
1971						
1972						
1973						
1974	37.0	42.7	31.9			
1975				33.8	39.3	28.9
1976	36.7	41.9	32.0			
1977						
1978	33.2	37.5	29.6			

Estimates from the 1978 Health Interview Survey indicate that 33.2% of the U.S. population 17 years of age and older smoke (Table 2). It has been estimated that 95% of the 29 million smokers who have quit since 1964 have done so on their own. Survey data show that only one-third or less of smokers motivated to quit are interested in formal programs, and only a small minority of those actually attend programs when offered. Objective data are lacking on most of the smokers who have attended formal programs, and controlled research has yet to produce a clearly superior intervention strategy. The current trend in adult-education programs is an emphasis on personal responsibility for health and on adoption of a health-promoting lifestyle.

Very few carefully designed and implemented longitudinal studies exist in the area of smoking in children and adolescents. The critical level for onset of habitual smoking appears to be in high school. Therefore, the true impact of any anti-smoking program with adolescents may not even be measurable until after the adolescent has entered high school.

A promising new approach to offset adolescent pressures to smoke involves strategies to resist peer pressure, to understand how advertising and mass media work to influence smoking, and to provide information on ways to resist the models of parents, siblings, and older students who smoke. Also included is a focus on the immediate physiologic effects of smoking, rather than on long-term effects. Researchers find that "significant adults" (such as physicians) are powerful influences on teenage smoking.

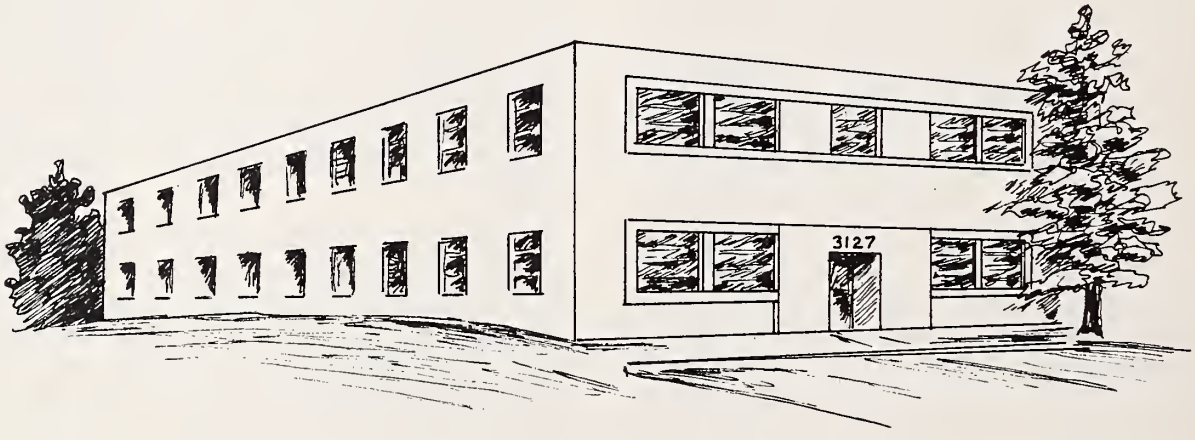
Involuntary Smoking: Only a limited amount of systematically collected information regarding the health effects of involuntary (passive or second-hand) smoking on the nonsmoker is available, and much of that centers on exposure to CO. Cigarette smoking in enclosed spaces can produce CO levels well above the Ambient Air Quality Standard (9 ppm), even where ventilation is adequate. These levels of CO have been shown to decrease the exercise threshold for angina in patients with coronary artery disease and for intermittent claudication in patients with peripheral vascular disease. In healthy adults, levels of carboxyhemoglobin produced in involuntary smoking situations are functionally insignificant.

Substantial proportions of healthy adults experience irritation of eyes and nose when exposed to cigarette smoke. Changes in psychomotor function, especially attentiveness and cognitive function, have been noted. In children of parents who smoke, bronchitis and pneumonia are more common during the first year of life than in children of nonsmokers.



Every man is a builder of a temple, called his body. . . . We are all sculptors and painters, and our material is our flesh and blood and bone.
Thoreau

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A 19th Century Perspective on the Health Consequences of Smoking

(Editor's note: This paper, published in the Confederate States Medical and Surgical Journal *in 1864, offers some interesting insight into the medical opinion of that day regarding smoking. Courtesy of the New York Academy of Medicine Library.)*

Effects of Tobacco. — In a paper read before the National Association for the Promotion of Social Science, Dr. Richardson comes to the following conclusions, in which every position has been founded upon individual research:

1. The effects that result from smoking are due to different agents imbibed by the smoker — viz: carbonic acid, ammonia, nicotine, a volatile empyreumatic substance, and a bitter extract. The more common effects are traceable to the carbonic acid and ammonia; the rarer and more severe to the nicotine, the empyreumatic substance, and the extract.

2. The effects produced are very transitory, the poison finding a ready exit from the body.

3. All the evils of smoking are functional in character; and no confirmed smoker can ever be said, so long as he indulges in the habit, to be well. But it does not follow that he is becoming the subject of organic and fatal disease because he smokes!

4. Smoking produces disturbances in the blood, of the stomach, of the heart, of the organs of sense, of the brain, of the nervous filaments and sympathetic or organic nerves, of the mucous membrane of the mouth, and of the bronchial surface of the lungs.

5. The statements to the effect that tobacco-smoke causes specific diseases — such as insanity, epilepsy, St. Vitus' dance, apoplexy, organic disease of the heart, cancer and consumption — have been made without any sufficient evidence or reference to facts. All such statements are devoid of truth, and can never accomplish the object which those who propose them have in view.

6. As the human body is maintained alive and in full vigor by its capacity within certain well-defined limits to absorb and apply oxygen, as the process of oxydation is most *active and most* required in those periods of life when the structures of the body are attaining their full development, and as tobacco-smoke possesses the power of arresting such oxydation, the habit of smoking is deleterious to the young.

7. In the main, smoking is a luxury which any nation of moral habits would be better without. The luxury is not directly fatal to life, but its use conveys to the mind of the man who looks upon it calmly, the unmistakable idea of physical detriment.

8. But as a luxury, tending to this condition, it is probably one of the least hurtful of luxuries. It is on this ground, in fact, that tobacco holds so firm a position: that of nearly every luxury it is the least injurious. It is inoccuous as compared with alcohol; it does infinitely less harm than sugar (?); it is in no sense worse than tea; and, by the side of high living, altogether it contrasts most favorably. It is most antidotal to gluttony.

9. Tobacco may also be considered, in certain cases, as a remedy for evils that lie deeper than its own, and as such a remedy, it will persist in holding its place until those evils be removed.

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Physicians Work to Eliminate Smoking

The Medical Association of Georgia's (MAG) Division of Education has tabulated the results of its recent all-member survey on smoking and found that an overwhelming majority of those responding are successfully attempting to eliminate or reduce smoking in their offices, hospitals, and other health-related facilities. The survey was conducted at the request of the MAG House of Delegates, which had adopted a resolution in 1977 urging physicians to assume leadership in the anti-smoking campaign.

The poll was conducted through both the *MAG Newsletter* and the *Journal of the MAG,* and 3% of the members completed the brief questionnaire. The results were as follows:

1) Are you aware of MAG's position on smoking in medically-related facilities? yes (63.9%)
2) Do you allow smoking in your office? no (75.7%)
3) Have you personally tried to get support for policies which would reduce smoking in your hospital or medical facility? yes (56.9%)

One physician described his efforts in realistic terms: ". . . removal of ashtrays in the office has partially resulted in burned carpet. . . ." Among other comments received were the following:

"Tried to get cigarettes off the cheer cart at [name of hospital], but the administration didn't have the guts to do it. MAG's support would help. Prohibiting cigarettes is not the idea, but discouraging their use is."

"MAG should push a request to *all* hospitals to remove cigarette vending machines from their institutions. Selling cigarettes in hospitals is *inconsistent.*"

"I personally believe that all hospitals, businesses, firms, manufacturers, etc. should prohibit smoking by individuals while they are on duty. This would raise productivity by 15%. This would have an effect upon hospital cost containment."

"Through my efforts, our hospital has eliminated all smoking by everyone in the halls, lab, X-Ray, and emergency area. We have also eliminated smoking by visitors within the hospital except in half the main waiting area, dining room, and snack bar. We have also eliminated the sale of smoking tobacco products (one doctor chews)."

"For God's sake, leave people the right to tend to their own business, good or bad!"

"I do not smoke myself, but I do not feel that I or anyone else has the right to make this decision for someone else."

The Division of Education conducted an additional survey, polling hospital administrators to find that a great majority of their institutions are actively involved in the anti-smoking campaign. This questionnaire was distributed to members of the Georgia Hospital Association, and representatives of 54.3% of the member institutions responded. This survey yielded the following results:

1) Has your institution developed any policies which would reduce the incidence of smoking? yes (75.2%)
2) Have any of your staff physicians urged that smoking be curtailed in your institution? yes (60.4%)

MAG members who have practical suggestions related to smoking in health facilities should address them to the MAG, Division of Education, 938 Peachtree Street, N.E., Atlanta 30309.

(This report was prepared by Sue McAvoy in MAG's Division of Education.)



HELP WANTED

Many young people have a difficult time during that developmental period of confusion, stress and conflict called adolescence. For some, this period of adjustment leads to serious and complex emotional problems — special problems requiring special help.

That help is available for persons 13 to 19 years of age through the Adolescent Services of Peachtree and Parkwood Mental Health Center and Hospitals. Under the supervision of psychiatrists, a highly trained staff of professionals helps teenagers find more rewarding and healthy behavior. Supervision by the adolescent's own therapist insures that special needs are recognized and dealt with in the treatment plan.

Complete information on Peachtree and Parkwood's Adolescent Services may be obtained by writing or calling the Admissions Office, Peachtree and Parkwood Mental Health Center and Hospitals, 1999 Cliff Valley Way, N.E., Atlanta, Georgia 30329 (404/633-8431).

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Is Georgia Medically Underserved?

M. JULIAN DUTTERA JR., M.D., *La Grange, and*
BERT FRANCO, M.A., *Atlanta**

SINCE ALL or at least a portion of 150 Georgia counties are designated as Medically Underserved Areas by the Department of Health, Education, and Welfare** (DHEW), the question of sufficient medical services inevitably arises whenever physicians, planners, government officials, physician's assistants, nurses, medical school faculty, or other health professionals discuss health care delivery in Georgia. Often there is little agreement on the extent to which Georgians are medically underserved and even less agreement on the methods for making such a determination. Yet we all recognize that there are areas in the state with less than the optimal number of physicians, something the Medical Association of Georgia is addressing through its Access to Health Care Committee, its Physician Placement Service, and numerous other activities designed to assist physicians wishing to practice in these areas. Still, the question remains: are Georgians able to get medical care when they need it?

The Health Systems Agency (HSA) of Central Georgia conducted a limited survey in an attempt to answer this question. The HSA surveyed 1304 residents in 23 counties, 920 of them by telephone and 384 through Community Action Agencies (CAA) which serve Georgia's poor.† Almost 90% of the telephone respondents and 75% of the CAA clients thought that they, as well as other members of their household, could get medical care when needed. In addition, less than 10% of the telephone survey group and only 30% of the CAA group stated that they had needed to see a physician in the past year and had not been able to see one. Combining the two groups, a total of 16% of all respondents stated that they were unable to see a physician when they thought they needed one.

Interestingly enough, of those respondents unable to receive care, only 28% gave reasons generally associated with an insufficient number of physicians, i.e., couldn't get an appointment, too far to a doctor. The remaining 72% cited financial reasons, lack of transportation, did not know a doctor, other reasons, or did not respond to the question. In other words, approximately 4.5% (.16 × .28) of all respondents were unable to get medical care for reasons suggesting a physician shortage, while 11.5% (.16 × .72) cited financial, educational, and other reasons affecting the utilization of physicians already in the area. These results indicate that there are barriers to receiving health care for a substantial portion of the population. They also suggest that the approach now being used by DHEW to improve access to health care, i.e., that of substantially increasing the supply of medical manpower, may be only a partial answer. More discretion on the part of the HSAs also may be useful in the designation of Medically Underserved Areas.

The preceding statistics indicate that the medical manpower shortage problem may not be as severe as indicated by DHEW, which has labeled at least part of every county served by the HSA of Central Georgia as Medically Underserved. The Georgia Department

* Dr. Duttera is Chairman of MAG's Access to Health Care Committee. His address is 303 Smith St., La Grange, GA 30240. Mr. Franco is Assistant Director of Medical Practice at MAG Headquarters, 938 Peachtree St., NE, Atlanta, GA 30309.

** According to latest estimates of the Division of Health Services Delivery, Public Health Service, DHEW, Region IV.

† Community Action Agencies are private non-profit agencies funded by the Community Services Administration (formerly the Office of Economic Opportunity). The offspring of the 1960's War on Poverty, these agencies advocate for the poor and deliver various services to this population.

of Human Resources also may find these statistics useful since it assists DHEW in placing National Health Service Corps personnel and is establishing Primary Health Care Centers and other mechanisms to provide health care in these underserved areas. Clearly, new initiatives to surmount the barriers to health care are needed in certain areas, but more in-depth study and local planning should be included in the development of any new programs.

The survey certainly could not be labeled as a definitive study of the health care needs of Georgians. It was limited to one area of the state, it was subject to the biases inherent in any personal survey, and the sample was extremely small. The results do indicate, however, the need for further examination of the criteria used to determine Medically Underserved Areas. These criteria (the primary care physician-to-population ratio, the infant mortality rate, the percentage of the population 65 and over, and the percentage of the population below the poverty level) should be considered in light of the fact that 83% of the respondents to the HSA survey stated that they are within 30 minutes of a physician and that more than three-fourths of the respondents had been seen by a physician in the year prior to the survey. The costs of a statewide survey such as this one would be prohibitive, but it may be the only way to obtain an accurate account of the medical needs of Georgians.



Lilies that fester smell far worse than weeds.
Shakespeare: *Sonnets*, XCIV, 1609

BRIEF SUMMARY OF
PRESCRIBING INFORMATION

ANTIMINTH® (pyrantel pamoate)
ORAL SUSPENSION

Actions. Antiminth (pyrantel pamoate) has demonstrated anthelmintic activity against *Enterobius vermicularis* (pinworm) and *Ascaris lumbricoides* (roundworm). The anthelmintic action is probably due to the neuromuscular blocking property of the drug.

Antiminth is partially absorbed after an oral dose. Plasma levels of unchanged drug are low. Peak levels (0.05-0.13 μg/ml) are reached in 1-3 hours. Quantities greater than 50% of administered drug are excreted in feces as the unchanged form, whereas only 7% or less of the dose is found in urine as the unchanged form of the drug and its metabolites.

Indications. For the treatment of ascariasis (roundworm infection) and enterobiasis (pinworm infection).

Warnings. *Usage in Pregnancy:* Reproduction studies have been performed in animals and there was no evidence of propensity for harm to the fetus. The relevance to the human is not known.

There is no experience in pregnant women who have received this drug.

The drug has not been extensively studied in children under two years; therefore, in the treatment of children under the age of two years, the relative benefit/risk should be considered.

Precautions: Minor transient elevations of SGOT have occurred in a small percentage of patients. Therefore, this drug should be used with caution in patients with preexisting liver dysfunction.

Adverse Reactions. The most frequently encountered adverse reactions are related to the gastrointestinal system.

Gastrointestinal and hepatic reactions: anorexia, nausea, vomiting, gastralgia, abdominal cramps, diarrhea and tenesmus, transient elevation of SGOT.

CNS reactions: headache, dizziness, drowsiness, and insomnia. Skin reactions: rashes.

Dosage and Administration. *Children and Adults:* Antiminth Oral Suspension (50 mg of pyrantel base/ml) should be administered in a single dose of 11 mg of pyrantel base per kg of body weight (or 5 mg/lb.); maximum total dose 1 gram. This corresponds to a simplified dosage regimen of 1 ml of Antiminth per 10 lb. of body weight. (One teaspoonful=5 ml.)

Antiminth (pyrantel pamoate) Oral Suspension may be administered without regard to ingestion of food or time of day, and purging is not necessary prior to, during, or after therapy. It may be taken with milk or fruit juices.

How Supplied. Antiminth Oral Suspension is available as a pleasant tasting caramel-flavored suspension which contains the equivalent of 50 mg pyrantel base per ml, supplied in 60 ml bottles and Unitcups™ of 5 ml in packages of 12.

More detailed professional information available on request.

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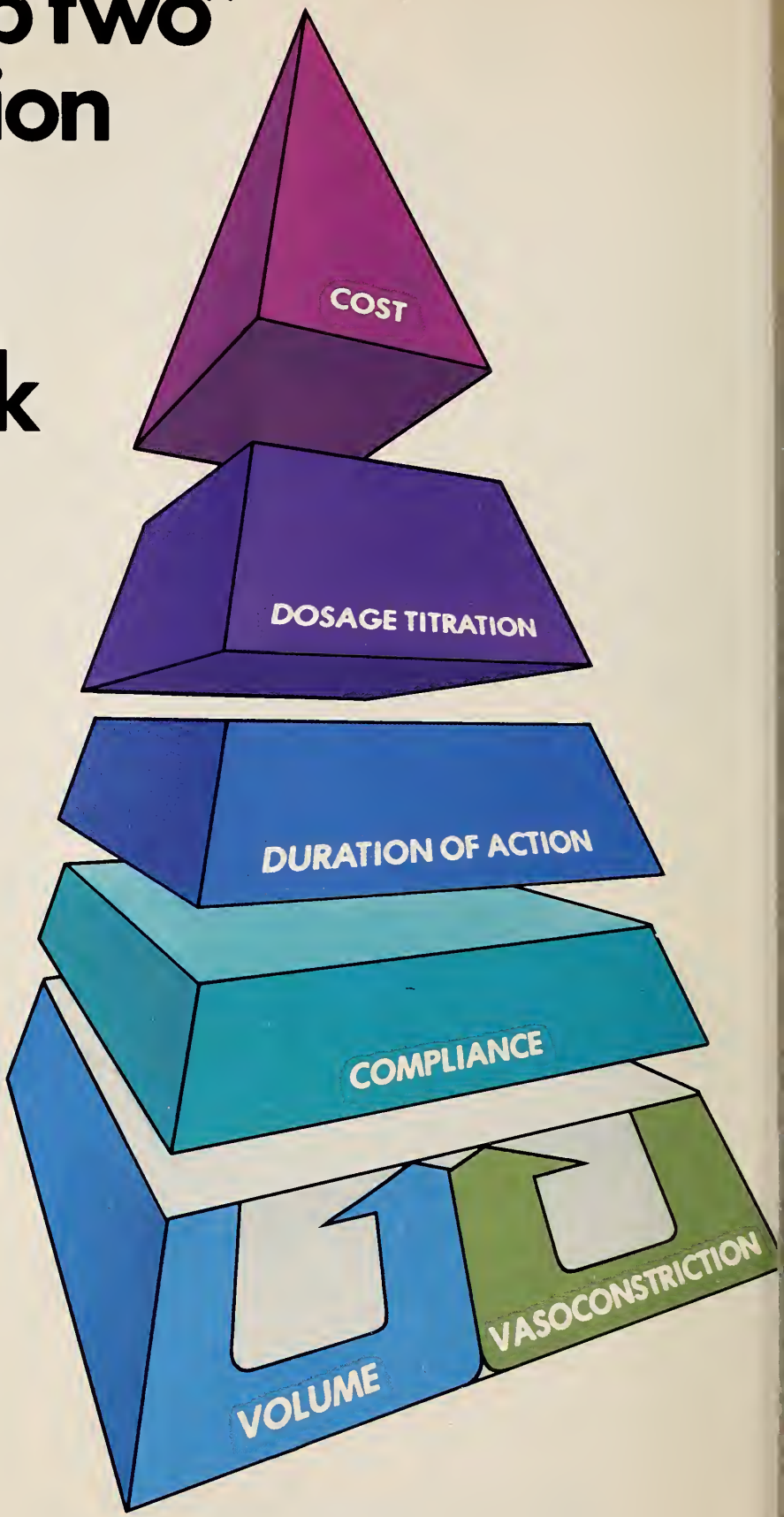


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Please see brief summary of prescribing information on facing page.

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(hydroflumethiazide 50 mg.)

Salutensin®
(hydroflumethiazide 50 mg./reserpine 0.125 mg.)

Salutensin-Demi™
(hydroflumethiazide 25 mg./reserpine 0.125 mg.)

the family of antihypertensives completing the therapeutic pyramid

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According to a recent study,[1] Salutensin® (hydroflumethiazide 50 mg./reserpine 0.125 mg.) was the most economical "step two" therapy... about ⅓ the cost of a day's supply of *thiazide* + *methyldopa* or *thiazide* + *propranolol*.[2]

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Salutensin contains the recommended effective doses of both its components, requiring minimal titration.

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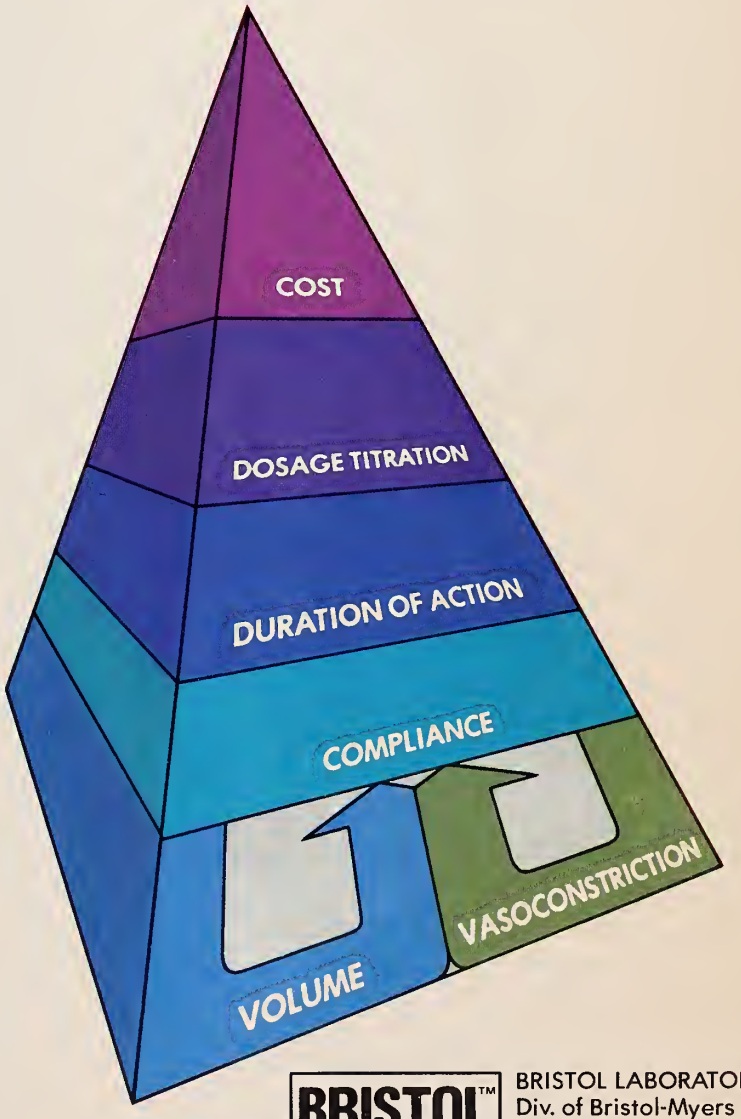
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References: 1. Finnerty, F. A. et al.: An Evaluation of Step 2 Regimens in Hypertension, data on file, Bristol Laboratories, 1977. 2. Red Book 1977.

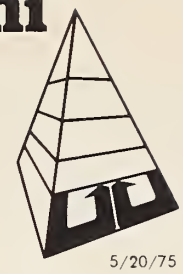
For a summary of prescribing information, please see following page.

Saluron®
(hydroflumethiazide 50 mg.)

Salutensin®
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structured for the long run in "step two" hypertension



Saluron® (hydroflumethiazide)

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For complete information consult Official Package Circular.

CONTRAINDICATIONS: Patients with anuria, oliguria, or hypersensitivity to this or other sulfonamide derived drugs.

WARNINGS: Saluron should be used with caution in severe renal disease. In patients with renal disease, thiazides may precipitate azotemia. Cumulative effects of the drug may develop in patients with impaired renal function.

Thiazides should be used with caution in patients with impaired hepatic function or progressive liver disease, since minor alterations of fluid and electrolyte balance may precipitate hepatic coma. Thiazides may be additive or potentiative of the action of other antihypertensive drugs. Potentiation occurs with ganglionic or peripheral adrenergic blocking drugs. Sensitivity reactions may occur in patients with a history of allergy or bronchial asthma.

The possibility of exacerbation or activation of systemic lupus erythematosus has been reported.

Usage in pregnancy: Usage of thiazides in women of childbearing age requires that the potential benefits of the drug be weighed against its possible hazards to the fetus. These hazards include fetal or neonatal jaundice, thrombocytopenia, and possibly other adverse reactions which have occurred in the adult.

Nursing mothers: Thiazides cross the placental barrier and appear in cord blood and breast milk.

PRECAUTIONS: Periodic determination of serum electrolytes to detect possible electrolyte imbalance should be performed at appropriate intervals.

All patients receiving thiazide therapy should be observed for clinical signs of fluid or electrolyte imbalance; namely, hyponatremia, hypochloremic alkalosis, and hypokalemia. Serum and urine electrolyte determinations are particularly important when the patient is vomiting excessively or receiving parenteral fluids. Medication such as digitalis may also influence serum electrolytes. Warning signs, irrespective of cause, are: Dryness of mouth, thirst, weakness, lethargy, drowsiness, restlessness, muscle pains or cramps, muscular fatigue, hypotension, oliguria, tachycardia, and gastrointestinal disturbances such as nausea and vomiting.

Hypokalemia may develop with thiazides as with any other potent diuretic, especially with brisk diuresis, when severe cirrhosis is present, or during concomitant use of corticosteroids or ACTH.

Interference with adequate oral electrolyte intake will also contribute to hypokalemia. Digitalis therapy may exaggerate metabolic effects of hypokalemia especially with reference to myocardial activity.

Any chloride deficit is generally mild and usually does not require specific treatment except under extraordinary circumstances (as in liver disease or renal disease). Dilutional hyponatremia may occur in edematous patients in hot weather; appropriate therapy is water restriction, rather than administration of salt except in rare instances when the hyponatremia is life threatening. In actual salt depletion, appropriate replacement is the therapy of choice.

Hyperuricemia may occur or frank gout may be precipitated in certain patients receiving thiazide therapy.

Insulin requirements in diabetic patients may be increased, decreased or unchanged. Latent diabetes mellitus may become manifested during thiazide administration.

Thiazide drugs may increase the responsiveness to tubocurarine.

The antihypertensive effects of the drug may be enhanced in the postsympathectomy patient.

Thiazides may decrease arterial responsiveness to norepinephrine. This diminution is not sufficient to preclude effectiveness of the pressor agent for therapeutic use.

If progressive renal impairment becomes evident, as indicated by a rising nonprotein nitrogen or blood urea nitrogen, a careful reappraisal of therapy is necessary with consideration given to withholding or discontinuing diuretic therapy.

Thiazides may decrease serum PBI levels without signs of thyroid disturbance.

ADVERSE REACTIONS:

A. Gastrointestinal system reactions: Anorexia, gastric irritation, nausea, vomiting, cramping, diarrhea, constipation, jaundice (intrahepatic cholestatic jaundice), pancreatitis.

B. Central nervous system reactions: Dizziness, vertigo, paresthesias, headache, xanthopsia.

C. Hematologic reactions: Leukopenia, agranulocytosis, thrombocytopenia, aplastic anemia.

D. Dermatologic-Hypersensitivity reactions: Purpura, photosensitivity, rash, urticaria, necrotizing angiitis (vasculitis) (cutaneous vasculitis).

E. Cardiovascular reaction: Orthostatic hypotension may occur and may be aggravated by alcohol, barbiturates, or narcotics.

F. Other: Hyperglycemia, glycosuria, hyperuricemia, muscle spasm, weakness, restlessness.

Whenever adverse reactions are moderate or severe, thiazide dosage should be reduced or therapy withdrawn.

USUAL DOSE: The average adult diuretic dose is 25 to 200 mg. per day. The average adult antihypertensive dose is 50 to 100 mg. per day. Therapy should be individualized according to patient response. This therapy should be titrated to gain maximal therapeutic response as well as the minimal dose possible to maintain that therapeutic response.

HOW SUPPLIED: Saluron (hydroflumethiazide 50 mg.): Bottles of 100.

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(hydroflumethiazide, reserpine antihypertensive formulation)

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> **WARNING**
> This fixed combination drug is not indicated for initial therapy of hypertension. Hypertension requires therapy titrated to the individual patient. If the fixed combination represents the dosage so determined, its use may be more convenient in patient management. The treatment of hypertension is not static, but must be reevaluated as conditions in each patient warrant.

CONTRAINDICATIONS: Anuria, oliguria, active peptic ulceration, ulcerative colitis, severe depression or hypersensitivity to its components contraindicates the use of Salutensin.

WARNINGS: Small-bowel lesions (obstruction, hemorrhage, perforation and death) have occurred during therapy with enteric-coated formulations containing potassium, with or without thiazides. Such potassium formulations should be used with Salutensin only when indicated and should be discontinued immediately if abdominal pain, distention, nausea, vomiting or gastrointestinal bleeding occurs. Use cautiously, and only when deemed essential, in fertile, pregnant or lactating patients.

Use in pregnancy: Thiazides cross the placenta and can cause fetal or neonatal hyperbilirubinemia, thrombocytopenia, altered carbohydrate metabolism and possibly electrolyte disturbances. Fatal reactions may occur with reserpine during electroshock therapy; discontinue Salutensin 2 weeks before such therapy. Increased respiratory secretions, nasal congestion, cyanosis and anorexia may occur in infants born to reserpine-treated mothers.

PRECAUTIONS: Azotemia, hypochloremia, hyponatremia, hypochloremic alkalosis and hypokalemia (especially with hepatic cirrhosis and corticosteroid therapy) may occur, particularly with pre-existing vomiting and diarrhea. Potassium loss may cause digitalis intoxication. *Potassium loss responds to potassium-rich foods, potassium chloride or, if necessary, discontinuation of therapy.* Serum ammonia elevation may precipitate coma in precomatose hepatic cirrhotics. Discontinue therapy 2 weeks before surgery or if myocardial irritability, progressive azotemia or severe depression occur. Exercise caution in patients with chronic uremia, angina pectoris, coronary thrombosis or extensive cerebral vascular disease or bronchial asthma and in those with a history of peptic ulceration or bronchial asthma; in postsympathectomy patients; in patients on quinidine; and in patients with gallstones, in whom biliary colic may occur. Patients who have diabetes mellitus or who are suspected of being prediabetic should be kept under close observation if treated with this agent.

ADVERSE REACTIONS: Hydroflumethiazide: Skin-rashes (including exfoliative dermatitis), skin photosensitivity, urticaria, necrotizing angiitis, xanthopsia, granulocytopenia, aplastic anemia, orthostatic hypotension (potentiated with alcohol, barbiturates or narcotics), allergic glomerulonephritis, acute pancreatitis, liver involvement (intrahepatic cholestatic jaundice), purpura plus or minus thrombocytopenia, hyperuricemia, hyperglycemia, glycosuria, malaise, weakness, dizziness, fatigue, paresthesias, muscle cramps, skin rash, epigastric distress, vomiting, diarrhea and constipation. **Reserpine:** Depression, peptic ulceration, diarrhea, Parkinsonism, nasal stuffiness, dryness of the mouth, weight gain, impotence or decreased libido, conjunctival injection, dull sensorium, deafness, glaucoma, uveitis, optic atrophy, and, with overdosage, agitation, insomnia and nightmares.

USUAL DOSE: 1 tablet b.i.d.

HOW SUPPLIED: Salutensin (hydroflumethiazide 50 mg., reserpine 0.125 mg.): Bottles of 100 and 1000.

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PSRO—The Light at the End of the Tunnel Is in Sight

JACK F. MENENDEZ, M.D., *Macon**

At its September 1977 Board of Directors Meeting, the Medical Association of Georgia (MAG) directed the Georgia Medical Care Foundation (GMCF) to become the Professional Standard Review Organization (PSRO) for Georgia. In complying with this direction, the GMCF signed a contract with the Department of Health, Education, and Welfare to design and implement a PSRO plan. The purpose of this article is to discuss four areas of interest and concern:

I. What has led to peer review in this country and elsewhere?
II. What is the relationship between organized medicine and PSRO?
III. What will be the effect of PSROs on patients, physicians, and hospitals?
IV. What are the implications of joining the PSRO?

I. What Has Led to Peer Review in This Country and Elsewhere?

As part of the research done by the GMCF, letters were sent to medical officials in all the free-world countries to find out if they had peer review systems and if so, what type. Of those who responded, only West Germany had a review system while two others, Spain and the United Kingdom, were contemplating one.

The peer review system in Germany spot checks quality of care, but only for laboratory and x-ray. There is no peer review of clinical practice, and none is anticipated. In Spain, a general tightening of standards including a peer review system was initiated as a result of an influx of foreign medical graduates, primarily from the Middle East. The National Health Service in the United Kingdom has drawn up a plan for a governmental peer review system. The plan is derived from the PSRO legislation in the United States. This has been opposed by the British Medical Association, which believes that peer review, medical audit, and continuing medical education should be voluntary.

The impetus for peer review through PSRO in the United States is primarily cost containment and secondarily quality assurance. The cost of PSRO ($149.8 million for the fiscal year 1980) must be weighed against the savings achieved through cost containment. Quality assurance will be difficult to assess, since objective evidence will be equally hard to obtain.

* Dr. Menendez is the President of the Georgia Medical Care Foundation. His address is 700 Spring St., Macon, GA 31201.

II. What Is the Proper Relationship Between Organized Medicine and PSRO?

Another aspect of the research conducted by the GMCF was to find out how the state medical societies regarded the PSROs in their states. We also questioned all conditional* PSROs about their functions and how they viewed their relationships with their medical societies. The replies were instructive. PSROs which had previously been foundations (as in Georgia) saw their roles more as promoting and assuring quality care, while newer PSROs saw their roles more as agents of the government in cost containment and policing the medical profession. Both the state medical societies and PSROs indicated that they were best maintained when there was strong physician support. The instruction for us is clear: if we want to have input into the PSRO, we must join it and help influence the direction of the PSRO.

III. What Will Be the Effect of PSROs on Patients, Physicians, and Hospitals?

The answer, if we organize it correctly will be — very little. GMCF believes that PSRO activities can take one of two directions: (1) non-delegation and little monitoring or (2) delegation and heavy monitoring. The large size of our state mandates as much delegation as possible, and GMCF/PSRO must therefore be responsible for monitoring the delegated activities. Georgia's PSRO will be one of the largest in the country, covering 58,876 square miles, 300,000 federally funded discharges, and approximately 6,000 physicians. A program with maximum delegated authority for binding review and responsible monitoring would therefore appear to be the most cost-effective approach for GMCF to pursue.

In order to abide by this philosophy, GMCF/PSRO will consider all previous in-house review activities and the resulting denial rates established by the Medicare fiscal intermediaries for individual hospitals, as preliminary reference points for assigning delegated status to hospitals in Georgia. Hopefully, about 90-95% of hospitals in Georgia will receive delegated status.

Accordingly, GMCF will monitor hospital and physician practices. The critical element of the monitoring system will be the Regional Review Committee, a group of local physicians that can function as a Utilization Review Committee for small hospitals so they can qualify for delegation. The regional Review Committee will provide for local peer review for all PSRO related activities, and only those matters which cannot be handled locally will be referred to the GMCF/PSRO.

Each of the ten Regional Review Committees will be coordinated and staffed by a Regional Review Coordinator (a nurse), who will be responsible for handling the on-site evaluation of each hospital's PSRO activities and for providing any technical assistance needed by the hospitals. He/she will be the liaison between the hospital and the PSRO.

Committee Structure

GMCF has set up committees to carry out its PSRO responsibilities. During the Planning Year, a PSRO Medical Advisory Committee was formed to recruit physicians so that GMCF could qualify for conditional designation. This committee has met three times to discuss recruitment activities and to make recommendations to GMCF's Board of Directors regarding PSRO policy decision. In addition to these activities, this committee will coordinate the Regional Review Committees.

Other committees to be established by GMCF are the Continuing Medical Education Committee and the Health Care Provider Advisory Committee. The Continuing Medical Education Committee will be responsible for directing appropriate educational activities as determined by medical care evaluation studies, either regionally or from individual hospitals. A Training and Education Coordinator will staff this committee and carry out its directions. The Health Care Provider Advisory Committee will consist of representatives from health fields other than physicians and will act in an advisory capacity to GMCF's Board of Directors.

* Conditional is an "in-house" term, meaning that the PSRO has begun implementing the program but is not yet fully independent.

IV. What Are the Implications of Joining the PSRO?

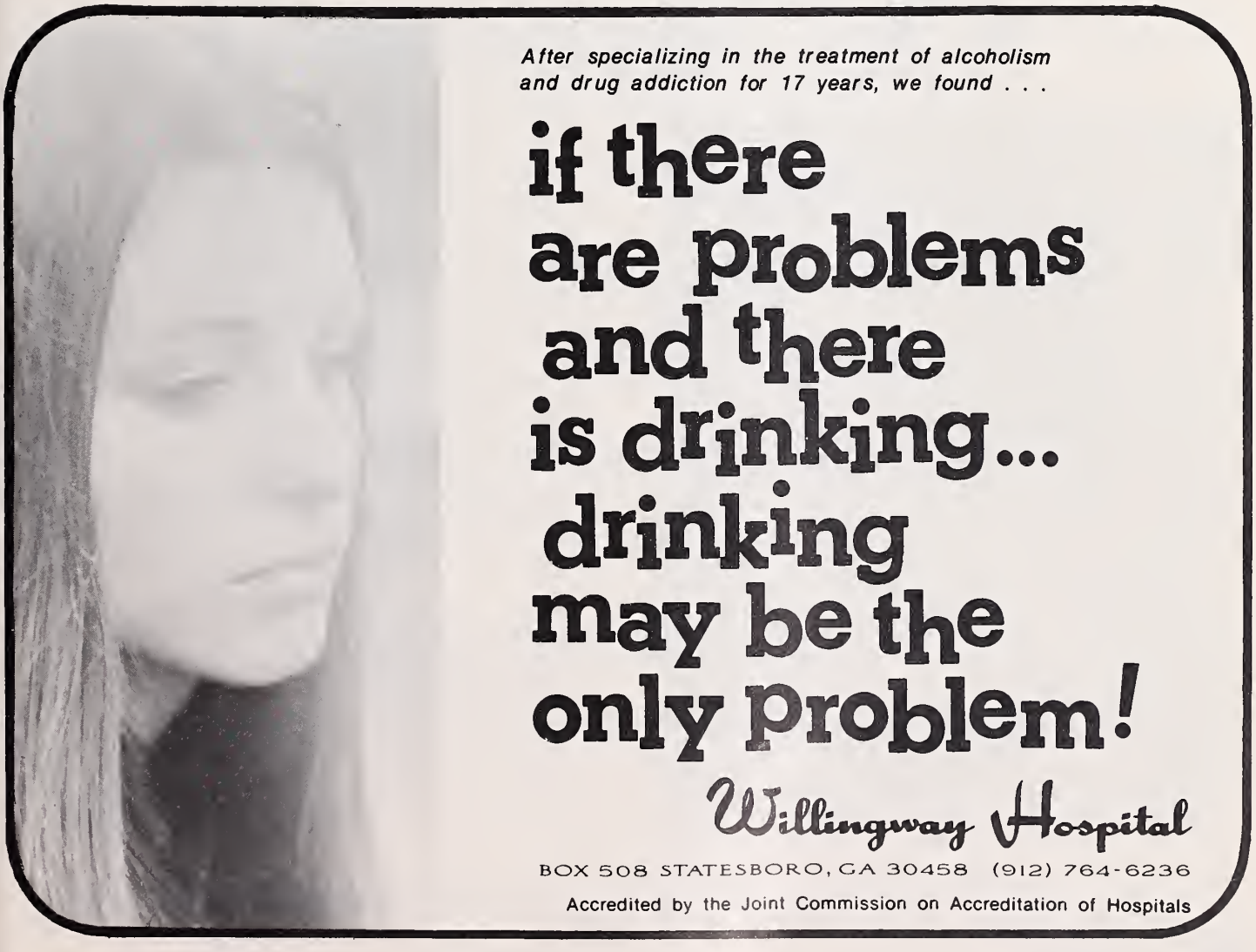
If you join the MAG-sponsored GMCF-run PSRO in the planning stage, you can help determine the method of peer review to be done at your hospital. Only PSRO members can structure the review process and conduct the review.

Hospitals also have the option to either do their own review or have the PSRO do it. In Georgia, we are doing all types of review required by PSRO. There is no reason or need for a hospital to relinquish its own review process. About 90-95% of the hospitals will be delegated to do peer review locally. Hospital review, as presently done, meets all the PSRO standards. If the reviewers are PSRO members, there will be a continuity of local review.

The PSRO, once it becomes conditional, will elect its policy-making Board of Directors from the PSRO members. If MAG members join the PSRO, they can effect a close-working relationship between organized medicine and the PSRO.

One of the doubts concerning PSRO is that we will move, conceptually, from a voluntary peer review system (GMCF) to a federally mandated system (PSRO). Another doubt is in the area of cost: For the fiscal year 1979, the budget for PSRO is $150,000,000. A third doubt is that concerning peer review itself. Does it have a valid positive impact on the practice of medicine? We have always had the bad apples, the money chiselers, and the dangerous practitioners among us. Will PSRO ferret out any more than GMCF? This remains to be seen.

If you have any questions regarding PSROs, please contact us at GMCF. Our WATS number is 1-800-282-2614.





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I grew up, moved away, and on to other things. But I never forgot Old Number 9. Guess that's why I joined the local club for fire engine buffs. Turned out there were a lot of us around. Enough of us to be able to pool our Savings Bonds and go looking for a fire engine to buy.

I finally found Old Number 9. Spending her retirement on the edge of a highway under a big "Mack's Red Hots" sign. But we changed all that. Today, Number 9 has the place of honor in every town parade. She leads the march down Main Street. With me at the wheel, of course.

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X-Ray Seminar No. 32

Meckel's Diverticulum

GURBHUSHAN SINGH BASRA, M.D., and THADDEUS LAMAR TEAFORD, M.D., *Atlanta**

DR. BASRA: The patient is a 34-year-old woman presenting with a transient history of right lower quadrant pain, ankle edema, fatigue, weight loss, hematochezia, and ice pica recurring over a 12-year period. At the age of 18 years, the patient was transfused with 3 units of whole blood for anemia (hematocrit 18) of unknown cause. Other pertinent past history includes prior hysterectomy, cholecystectomy, pelvic floor repair surgery, and negative diagnostic evaluation (including upper gastrointestinal (GI) series, barium enema, and proctosigmoidoscopy) 9 months prior to admission. Physical examination revealed a pale, obese woman with normal vital signs. Laboratory studies showed a mild, guiac positive stool and hematocrit of 20.3, with red blood cell indices indicative of hypochromic, microcytic anemia. Post-admission, the nasogastric tube aspirate was negative, and proctosigmoidoscopy showed a few hemorrhoids. Dr. Teaford, would you evaluate the initial radiologic examination, a barium enema.

Dr. Teaford: Pre- and post evacuation barium enema films (Figure 1) show an apparently normal large bowel and a terminal ileum reflux into a 5 cm. size "diverticulum-like" stricture. The diverticulum demonstrates movement from the right upper quadrant to the pelvis, varying from supine to erect positioned abdominal radiographs.

In view of the clinical history, a Meckel's diverticulum would be the primary diagnosis, particularly since it is at times demonstrated incidental to a



Figure 1—Post evacuation barium enema film shows 5 cm. size "diverticulum-like" structure extending from terminal ileum, as indicated by arrows. Transient peristaltic contraction can be seen in mid-descending colon.

* Drs. Basra and Teaford are from the Department of Radiology, Emory University School of Medicine, Atlanta, GA 30303.

barium enema. Other considerations would include intestinal duplication cyst and solitary, wide mouth, small bowel diverticulum (ileum being the most common location for solitary and jejunum for multiple). Meckel's diverticulum, which arises from the antimesenteric border of the ileum in all but 6% of cases, can be differentiated from these two entities, which always arise from the mesenteric border of the small bowel.

Dr. Basra: Dr. Teaford, would you please comment on the radiopertechnetate scan, and upper GI series-small bowel follow through performed the following day.

Dr. Teaford: After 5 mCi of 99mTc pertechnetate was administered intravenously, multiple gamma camera scans of the abdomen were obtained over a 60-minute period. A localized focus of increased radioactivity was demonstrated in the right midabdomen (Figure 2), surrounded by a halo of absent activity and seen best in the later scans. Normal increased activity was noted in the stomach and proximal small bowel from gastric mucosa uptake and secretion of pertechnetate and in the bladder area from renal excretion. The above findings are characteristic of ectopic gastric mucosal radioisotope uptake in a Meckel's diverticulum. Although less likely, false positive abdominal scintigrams have been attributed to intussusception, hydronephrosis, arterio-venous malformation, acute obstructed loops of small bowel, abdominal abscess, leiomyoma, and peptic ulceration.

The upper GI series-small bowel follow through, as expected, demonstrated the diverticulum, but less optimally than the barium enema examination.

The clinical and radiographic findings are compatible with a Meckel's diverticulum containing ectopic gastric mucosa with associated ulceration and hemorrhage. Exploratory laparotomy for confirmation would be the treatment of choice.

Dr. Basra: Exploratory laparotomy was performed. A Meckel's diverticulum was identified in the terminal ileum, and the involved segment of ileum was resected, followed by end-to-end anastomosis of the ileum.

Gross pathologic examination showed an active, penetrating, peptic ulceration and non-specific enteritis in a Meckel's diverticulum. Pyloric-type glands were identified in the mucosa of the diverticulum by microscopic examination.



Figure 2—The 60 minute 99mTc pertechnetate gamma camera scan of the abdomen shows localized focus of increased activity (indicated by arrows), surrounded by a halo of absent activity. Normal increased activity noted in stomach, proximal small bowel, and bladder.

Discussion

Occurring in 2-3% of all people, Meckel's diverticulum is said to be the most frequent anomaly of the GI tract. It results from incomplete closure of the omphalomesenteric duct, usually obliterated and detached from the embryo by the 5th week of gestation. Classically occurring 30-40 cm. from the ileocecal valve, it microscopically consists of full thickness of bowel wall, and 12-50% are said to contain ectopic tissue, most commonly gastric mucosa, less frequently pancreatic and colonic.

A structure whose presence is usually of no significance, the Meckel's diverticulum has been reported to have a complication rate varying from 4-25%. Common presentations include hemorrhage due to peptic ulceration of ectopic gastric mucosa, small bowel obstruction due to intussusception or volvulus, and diverticulitis mimicking acute appendicitis. Less commonly, Meckel's diverticulum has been complicated by perforation, and rarely by tumors, including carcinoma, sarcoma and carcinoid.

In 1933, Charles Mayo observed that, "Meckel's diverticulum is frequently suspected, often looked for, and seldom found." This has been attributed to its relatively wide mouth, absent or little lymphoid tissue, and self-emptying characteristics. Routine examination of upper GI series, small bowel follow through, and barium enema usually prove to be unsuccessful in demonstrating a Meckel's diverticulum. Abdominal angiography has at times proven effective in demonstrating an actively bleeding Meckel's diverticulum. When clinical suspicion for Meckel's diverticulum is high and utiliza-

tion of endoscopy or arteriography is being entertained, a radiopertechnetate scan should always be considered, since it is simpler and safer to perform. Although most often negative, the 99mTc pertechnetate scan for Meckel's diverticulum is very helpful. If this diagnostic study proves to be positive, it will not only provide the surgeon with a satisfactory pre-operative diagnosis but will also obviate the need to perform the more complex, invasive, and potentially hazardous diagnostic procedures.

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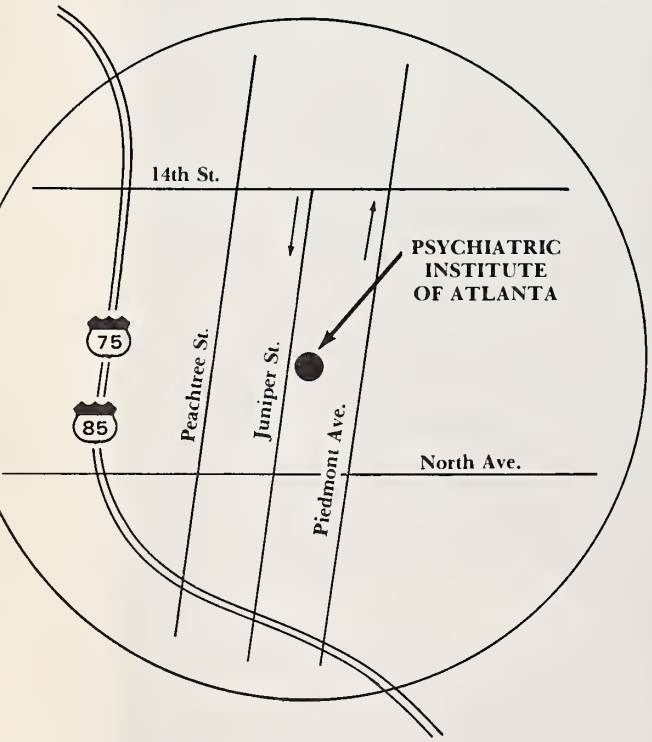
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Subdural Hematoma

JAMES M. BLUE, M.D., *Augusta**

A SUBDURAL HEMATOMA (SDH) is an accumulation of blood within the subdural space. The rate at which this accumulation occurs, the time required for clinical presentation related to the time of the original injury, and the characteristics at the time of surgery are all means of classifying the type of the hematoma. Acute SDHs present with neurologic symptoms immediately after injury, subacute within 2-10 days. Pathologically, both may be solid. This is in contrast to the chronic SDH which may present weeks or months after an injury, if history of such an event is present at all. By this time, the blood products have broken down, and fibrin organization has been lost, accounting for the "motor oil" appearance of the hematoma.

The shorter the time between the original injury and the onset of symptoms, the higher the mortality. The mortality associated with SDH is 80% in the first 12 hours, 40% in the next 36 hours, and 15% thereafter.[11, 19] The high mortality in the early hours may be due to the SDH but is often secondary to associated head or bodily injury.

Some additional statistics are: (1) SDH occurs in 5% of all head injuries;[19] (2) the percentage which occurs with fracture is equal to that which occurs without; (3) SDH often, but not always, occurs beneath a fracture; (4) 20% are bilateral (these tend to be in older patients); (5) 25% have associated intracranial lesions requiring surgery including, 15% with extradural hematoma, both ipsi- and contralateral to the SDH, 15% with intracerebral hematoma, and 3% with all three together; (6) SDH may be found anywhere within the dura, but the surface over the convexities is the most likely site (Figures 1-2). It rarely occurs in the posterior fossa.

The extreme variability of presenting symptoms makes early, accurate diagnosis particularly difficult.

Presentation

Presentation of an acute SDH can vary greatly. Often, symptoms from generalized brain injury may overshadow those resulting from the SDH. This may account for the high morbidity and mortality. If anything may help to distinguish SDH from other intracranial pathology, it may be its character as an expanding intracranial lesion. Therefore, symptoms may change or lateralize while the patient is under observation.

As noted above, presentation of a subacute or chronic SDH is usually different from that of an acute SDH and may be subtle and deceptive. Patients with such lesions are sometimes admitted to psychiatric institutions with signs of psychiatric dysfunction, including nervousness, irritability, irascibility, and stupor, with no history of prior trauma. In one study, 8% of patients admitted to a psychiatric institution were diagnosed as having subacute or chronic SDH. In another instance, autopsy of chronically-ill patients admitted to a psychiatric service revealed SDH to be the cause of death in 1.1%.[21] It is important, therefore, that SDH be considered in the differential diagnosis of chronic psychiatric patients.

There are other symptoms of chronic SDH which present more obviously. More than 90% are characterized by headache,[5, 18] usually on one side. Lateralizing signs are often present, but may be

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subtle and sometimes conflicting. Only 20% will have papilledema, this occurring in 53% of those under the age of 20 but in only 16% of those over 50.[5]

Diagnostic Studies

An echoencephalogram can be used to check for evidence of shift of the midline by a mass lesion. Unfortunately, it is unreliable not only in evaluating shift but also in detecting bilateral SDH (20%), where there may be no shift. For this disease, the test is reliable in only 50% of cases.[9]

Radionuclide scanning has been extremely helpful in diagnosing chronic SDH and remains one of the best examinations available, particularly in light of its relatively small risk. Over 90% of cases are diagnosed[9] (Figures 3-4).

The accuracy of CAT scanning in diagnosing SDH had originally been in doubt, due to the technical difficulty in differentiating fresh hematoma from the inner table of the skull and chronic hematoma fluid from the border of contiguous brain. With the use of contrast enhancement, however, displaced cortical vessels can be seen, delineating the border of the hematoma on the surface of the brain, thus facilitating diagnosis, and increasing the usefulness of the CAT scan[8] (Figure 5).

Angiography is another diagnostic tool. It is being used less often, however, as the use of the previous two studies has increased (Figures 6-7).

In some major institutions, so-called "blind" trephining continues to be used, not only for therapeutic but also for diagnostic purposes as well. These are usually done bilaterally in two or three standard positions or at a fracture site. Diagnostically, blind trephines may miss the hematoma but may be crucial in a neurologic emergency.

Pathogenesis

Acute SDHs usually result from a traumatic tear of the veins bridging the subdural space (Figure 8). Most of the bridging veins are found near the major intracranial venous sinuses, particularly the superior sagittal and the transverse. Cerebral contusions which tear other surface vessels or extension of bleeding from the subarachnoid or intracerebral spaces may also produce SDHs. Finally, blood dyscrasias with attendant coagulopathies must also be considered.

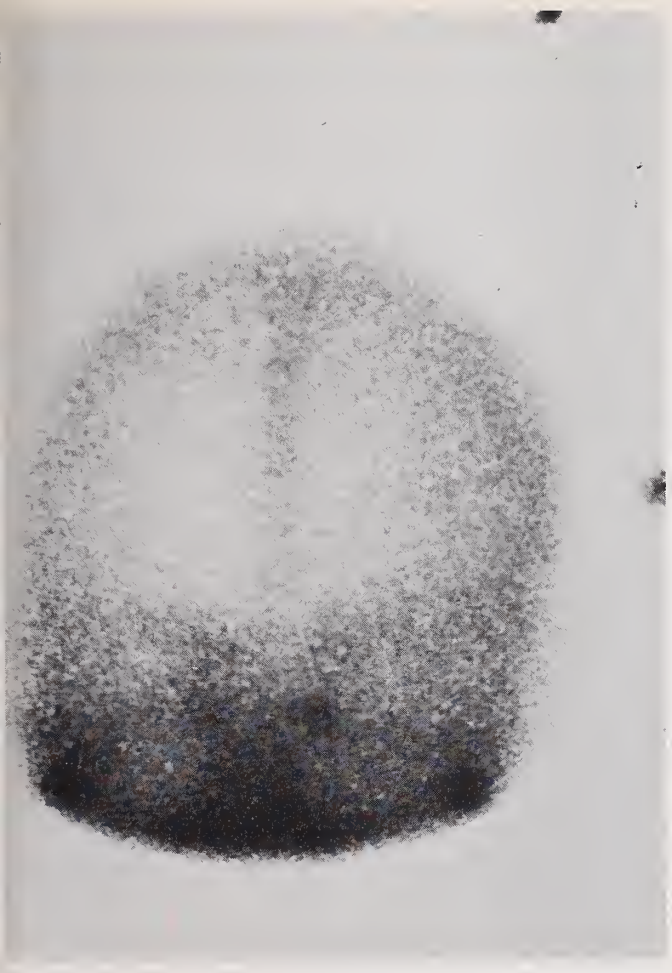
The pathogenesis of chronic SDH has been debated for many years and is still not settled. The incriminating head trauma is often minor, and it may go unrecognized (less than 50% by history).[5] Subdural bleeding ensues but is often not enough to be clinically symptomatic. This raises the following questions: (1) Why is the hematoma not reabsorbed,

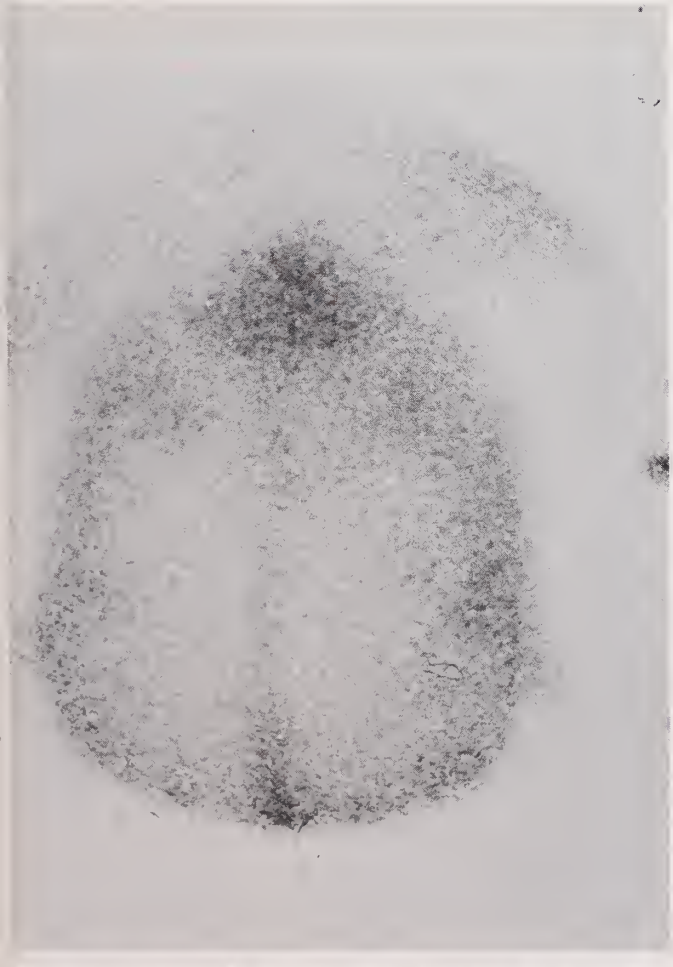


Figure 1 — Post-mortem specimen showing posterior dura pulled up to reveal an acute SDH (Courtesy F. Yaghmai, M.D.).



Figure 2 — Dura removed completely showing bilateral acute SDH on inner surface of dura (Courtesy F. Yaghmai, M.D.).





Figures 3 and 4 — Radionuclide brain scan of right-sided SDH (Courtesy M. E. Morgan, M.D.).

as is the case in other areas of the body? (2) What accounts for the enlargement, acutely or chronically, of an SDH until the lesion becomes symptomatic?

In 1914, Trotter explained episodes of clinical deterioration as being due to renewed hemorrhage from bridging veins.[20] Putnam and Cushing, in 1925, agreed that deterioration came from rebleeding, since fresh red blood cells (RBC) could be found in chronic subdural fluid.[15] However, they felt rebleeding came from thin-walled sinusoidal vessels in the outer or dural surface of the encapsulating membrane rather than from bridging veins. In 1932, Gardner theorized that enlargement of the hematoma could be accounted for by the breakdown of cellular elements, resulting in an osmolar gradient across the membrane.[6] Cerebrospinal fluid (CSF) or capillary water would flow with the gradient into the membrane, causing the space to enlarge until pressures equilibrated. This he demonstrated using a model of subdural hematoma fluid in an artificial membrane immersed in CSF. The volume of the container increased over 50%. When this experiment was duplicated using human subdural membrane, however, no significant change in volume occurred.

Several factors were left unanswered by this latter theory. First, when chronic SDHs are tapped following an episode of clinical deterioration, fresh RBCs are routinely found. Second, there is no evidence to suggest that the arachnoid is permeable in osmolar inequality. Third, the major osmotic protein in SDH is albumin, which is not a component of blood breakdown products. Further studies have shown that the albumin comes from the intravascular compartment rather than from the subdural. Apfelbaum has recently concluded that Putnam and Cushing's theory is likely to be correct, since he has demonstrated RBCs being discharged from sinusoidal vessels in the outer membrane in animal models.[1] He also points out that, unlike some human SDHs, those in animals are invariably reabsorbed and, in fact, no animal model of a chronic SDH has ever been produced. Apfelbaum suggests that SDHs may not be reabsorbed because of craniocerebral disproportion. He points out that chronic SDH tends to be a disease of the elderly and alcoholic, both of whom have potentially large subdural spaces due to atrophy of the brain.[1]

Chronic SDHs begin as clinically undetected hemorrhages. They are not always reabsorbed because the surface area of the membrane in those patients with atrophy is not large enough. This can be demonstrated geometrically. The volume of a sphere increases logarithmically with increase in surface area and diameter. Once a subdural space becomes established in this way, sudden episodes of deterioration may be explained by fresh rebleeding as mentioned above.

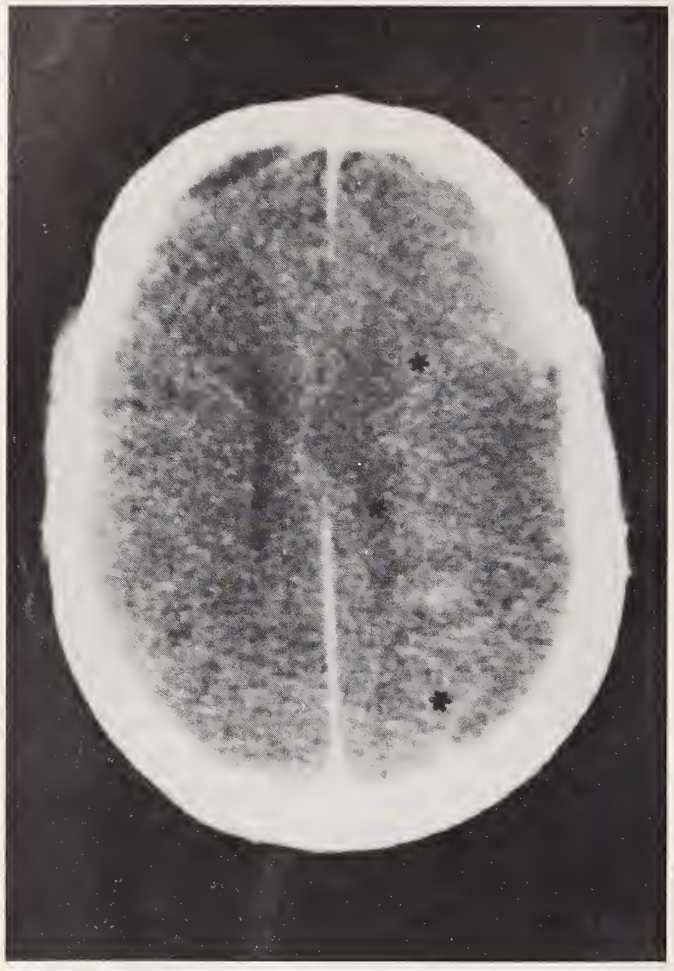


Figure 5 — CAT scan with contrast enhancement showing large right SDH displacing surface cortical vessels (asterisks) medially.



Figure 6 — Anterior-posterior view of right carotid arteriogram showing downward displacement of cerebral vasculature by a large SDH.

Treatment

Surgical therapy of acute and subacute SDH begins with trephination. If the position of the SDH is known, burr holes may be placed at the margins and the clot gently irrigated from the brain surface. If a diagnostic contrast procedure (EMI or angiography) is not available, as when emergency treatment is imperative, exploratory trephining may be performed in standard positions to examine the brain surface. Standard sites for exploratory burr holes include: (1) just anterior to the coronal suture and one inch off midline, (2) one inch above and one inch anterior to the external auditory canal, and (3) one inch above and one inch behind the pinna. Trephining at a fracture site or beneath a scalp contusion is often successful, but the hematoma can be remote from the point of a surface injury. A suboccipital hole may be included, which would be placed one inch below the transverse sinus and one inch off midline. If necessary, the temporal burr hole may be enlarged to a subtemporal craniectomy. This allows visualization of the anterior temporal lobe and frontal pole where, as Jamieson points out, acute injury to the brain frequently occurs against the "dashboards of the skull."[11] Also, it may occasionally be



Figure 7 — Lateral view: arrows point to margin of surface vessels pushed downward by SDH.

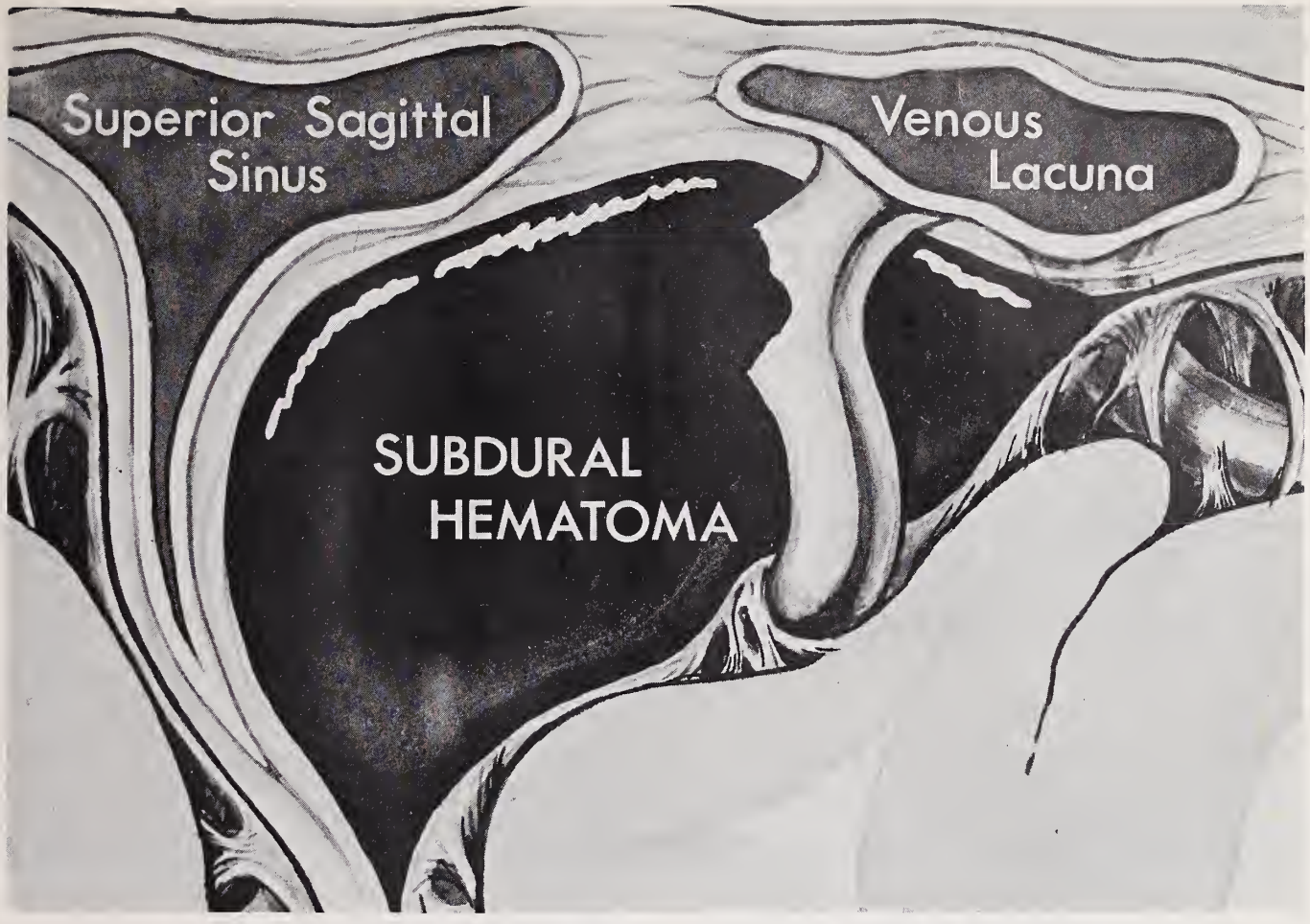


Figure 8 — Pathogenesis of acute SDH from rupture of vein bridging subdural space.

necessary to convert the trephine holes into a craniotomy since fresh clots are often difficult to wash out of the wound. Membranectomy was advocated as the procedure of choice for treating chronic SDH until the early 1960s. In 1963, Svien and Gelety[18] compared the results of membranectomy with simple trephination. They found that results of frequency of recurrence, final outcome, follow-up, and eventual development of seizures were all better after simple trephination. In our experience, trephination combined with post-operative drainage of the subdural space yields excellent results.

A recent innovation in the treatment of chronic SDH is that of non-operative therapy consisting of bed rest and corticosteroids. Dr. Bender treated a group of 97 patients in this manner, and 75 had both symptomatic improvement and reduction in the size of the hematoma. The remaining 22 eventually required surgery. Nine of his patients were seen within 48 hours of the time of injury, and the hematomas were accordingly classified as acute or subacute. Five patients responded to medical therapy, and four required surgery. The majority of the patients (58) had a complete recovery within 1 month; the remainder recovered within 3 months. Although therapy of this nature required prolonged hospitalization for observation, later in the series patients were completing their recovery at home, after only 1-2 weeks of hospitalization.[2] Medical therapy appears to be a reasonable alternative to surgery in patients under close observation in experienced hands.

SDH in Children

Acute SDHs in children appear to differ little from their counterpart in adults. They are usually the result of trauma and are often associated with underlying brain injury. They have a high morbidity and mortality; the surgery involved is essentially the same as that used for adults.

Chronic effusions in children, on the other hand, are different from those in adults in many ways. The cause in some is infection. Effusions are more frequently bilateral, with communication between sides. Pathologically, the membrane is thin and transparent in contrast to the adults' which is thick, opaque, and shaggy. If persistent, it will calcify which rarely occurs in adult chronic SDH. The fluid is often clear and yellow and high in protein.

Treatment formerly consisted of tapping as long as fluid persisted. In infants and small children, how-

ever, protein depletion may become a problem if tapping is continued for long periods. This led to the use of membranectomy to avoid this complication. It was believed that if the subdural membrane remained, it might damage and otherwise restrict the growth of the brain. In two different studies in 1960, Collins and Pucci[3] and Shulman and Ransohoff[6] introduced subdural-peritoneal shunting as an alternative method of treatment. The results were excellent and this removed the necessity for the more extensive procedure which they felt was not only futile, due to the extent of the membrane, but also often unsuccessful. Recently, McLaurin[12] has advocated nonoperative treatment, i.e., repeated tapping. To avoid the problem of protein depletion, he advocates tapping for increased pressure only, not for persistent fluid. The results to date are good, and according to his report of 15 children so treated, I.Q. results on follow-up match that of a surgically treated group.[13]

Summary

SDH varies in its presentation, ranging from a life-threatening, expanding intracranial lesion to a mild, unilateral headache. Accordingly, treatment following localization can involve emergency decompression, simple drainage, or bed rest. Chronic SDH in children appears to be somewhat different and is best treated by a subdural-peritoneal shunt or possibly repeated tapping for increased pressure.

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It is easy to know and do right. When in doubt, simply do whatever you least want to do.

Author unknown

The mechanics of donor tissue processing and the valuable role the practicing physician can play in furthering sight-restoration are discussed.

Georgia Eye Bank Restores Sight

LOUIS A. WILSON, M.D., JANIE BENSON, and BRUCE I. BODNER, M.D., *Atlanta

In Georgia, more than 200 people annually need a corneal transplant. There are two Eye Banks in the state, sponsored by the Georgia Lions Lighthouse Foundation, that provide tissue to ophthalmologists for such operations. One is affiliated with the Emory University School of Medicine in Atlanta, the other with the Medical College of Georgia in Augusta. The Eye Banks have experienced unprecedented growth, supplying over 450 corneas for transplant in the past year; however, the need for eye donations is still great.

The Georgia Lions Eye Bank uses the donor pledge system in which an individual completes a card, and keeps part as a wallet identification. In its promotional material, the Eye Bank also urges donors to inform their next-of-kin, family doctor, and clergyman of their decision, and to have this information included on their driver's license.

Over 90% of the donations now received by the Eye Bank are obtained through permission of the next-of-kin at the time of death. This authorization is carried out under the provisions of the Georgia Anatomical Gifts Act (1969). Physicians and nursing staffs in several Georgia hospitals have been very cooperative in routinely conveying the eye donation request to family members. If a family wishes to make a donation, written permission must be given. Eye Bank permission slips or an improvised form may be used, signed by the next-of-kin, two witnesses and dated.

The task of talking with a family is a difficult one. It requires tact and sensitivity on the part of the doctor. Physicians who regularly discuss this opportunity with families have found the following approach to be effective: "There are a number of people in Georgia who are blind. They could be given sight through a corneal transplant. Through his (her) eye donation, your husband (wife, etc.) could give sight to two people. Do you think (s)he would have wanted this?" Assure the family that the appearance of the eye donor remains the same, so they can plan the type of funeral they wish. There is no expense to the donor's family, as the cost is assumed by the Eye Bank.

One of the few contraindications to using corneas for transplant is septicemia. Tissue from donors with cancer, however, *can* be used for transplant surgery. The Eye Bank also provides sclera for ocular plastic surgery. Research investigations benefit from the availability of donor eye tissue, including corneal preservation, cataract, and glaucoma studies. That the donor wore glasses or had other eye problems does not rule out using his/her corneas for transplant. There is no age restriction regarding donors.

In the Atlanta and Augusta metropolitan areas, a technician or resident physician is on duty at all times to perform the sterile enucleation (removal) in the hospital or funeral home. In other communities, Eye Bank-trained, licensed embalmers provide this service. The procedure itself is relatively simple. It

* Medical Director of the Georgia Lions Eye Bank in Atlanta, Dr. Wilson is Professor of Ophthalmology, Emory University School of Medicine. Ms. Benson is the Eye Bank's Executive Director. Dr. Bodner is a Corneal Fellow in Emory's Ophthalmology Department. Dr. Wilson's address is Emory University School of Medicine, Department of Ophthalmology, 1365 Clifton Rd., NE, Atlanta, GA 30322.

takes about 20 minutes and can be performed in the hospital room, morgue, or funeral home. It should be performed within 6 hours after death. The tissue is then taken to the Eye Bank where it is examined to determine its suitability for transplant. If it is, it is preserved in tissue culture media which keeps it viable for surgery for up to 96 hours. This, of course, helps both the ophthalmologist and his patients tremendously, because it allows more flexibility when scheduling surgery.

The future of corneal transplant surgery and the Eye Banks is promising. A new development toward tissue matching between donor and recipient gives hope to the 5% of transplant recipients whose grafts are repeatedly rejected. Examination and photographing of the back layer of corneal cells with a specular microscope will increase the probability that healthy tissue is being transplanted. In addition, new methods of preserving tissue for several weeks are under development.

No transplant surgery or research can continue without eye donations.

Georgia physicians can make a vital contribution to sight restoration. Regularly talking with the families of deceased patients about eye donation means the difference between sight and blindness for those in need of a transplant, returning them to active life in their communities.

For more information, contact the nearest Eye Bank:

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Atlanta, Georgia 30322
(404)321-9300 (24 hr. number)

Georgia Lions Eye Bank
Medical College of Georgia
Augusta, Georgia 30902
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Final classification of the less-than-effective indications requires further investigation.

Contraindications: Glaucoma; prostatic hypertrophy, benign bladder neck obstruction; hypersensitivity to chlordiazepoxide HCl and/or clidinium Br.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants, and against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Physical and psychological dependence rarely reported on recommended doses, but use caution in administering Librium® (chlordiazepoxide HCl) to known addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions) reported following discontinuation of the drug.

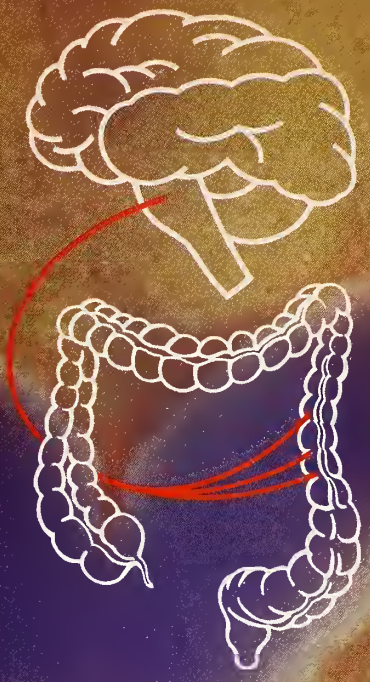
Usage in Pregnancy: **Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy. Advise patients to discuss therapy if they intend to or do become pregnant.**

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Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude ataxia, oversedation, confusion (no more than 2 capsules/day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacology of agents, particularly potentiating drugs such as MAO inhibitors, phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions reported in psychiatric patients. Employ usual precautions in treating anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship not established.

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president's letter

The Letter Revisited

REMEMBER the thought-provoking letter printed in the *Journal* last year, the one featured on the cover? (JMAG 67:8, August 1978) It was written by a concerned physician who had attended the 1978 Annual Session. He had arrived at Jekyll Island as a first-time delegate, disenchanted with the way things were going in the medical field and skeptical about any constructive action coming out of the meeting. He dutifully attended the all-day session of the House of Delegates, the reference committee meetings, and the all-important floor debates where decisions were hammered out in a democratic manner. And his viewpoint changed. He was amazed at the work involved and at how much really was accomplished. He left quite proud of the Medical Association of Georgia (MAG) and of what it was doing for the private practice of medicine.

Your local medical society, the MAG, and the American Medical Association comprise a federation of organized medicine which is shaping the destiny of medicine. It is a unifying body that blends the viewpoints of all physicians and structures them into concerted and effective action. As it was in the beginning, it is still true now: the strength of organized medicine is derived from the participation and support of individual physicians . . . from *you*.

Join us this year at our April Annual Session. See first hand how your elected delegates conduct the business affairs of your Association. Who knows? You might even want to become a delegate and participate yourself. Organized medicine needs you — your membership and your active participation.

So come to Savannah, and attend the 125th MAG Annual Session. You are most welcome!

Sincerely,

Carson B Burgstiner MD

Carson B. Burgstiner, M.D.
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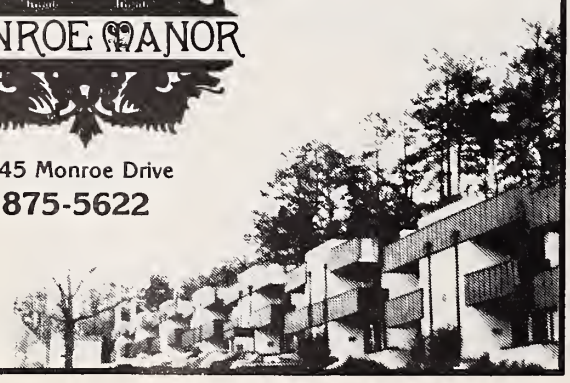
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A Time to Participate

At our upcoming meeting of the House of Delegates in Savannah, we shall see the highest governing body of our Association in action. Many vital issues will be considered and acted upon. Some of the topics discussed will include: Health Systems Agencies, American Medical Association ethics, National Health Insurance, physicians assistants, nurse practitioners, Health Maintenance Organizations, rural health clinics, fee schedules for Medicare and Medicaid, and Composite State Board disciplinary action.

It is the duty and prerogative of every member to inform himself of the issues and to communicate his opinions to his respective delegates. Only by this process may our duly elected representatives reflect the will of the membership.

Another means of contributing to the democratic process is attendance at the deliberations of the reference committees. Here, any member may listen to the deliberations and express his opinion. It is only with such input from our members that our committees can make sound recommendations to the House of Delegates.

Whether or not you are a delegate, make it a point to come to Savannah in April to witness and participate in the workings of your Association. Only at such close range can one be accurately informed about the vitally important work being conducted by your organization.

In addition, the beauty, charm, and hospitality of our state's oldest city await you. Make your reservation now for a fulfilling experience in Savannah.

Edgar Woody Jr., M.D.
Editor, JMAG



SEA-FEVER

I must go down to the seas again, to the lonely sea and the sky,
And all I ask is a tall ship and a star to steer her by,
And the wheel's kick and the wind's song and the white sail's shaking,
And a grey mist on the sea's face and a grey dawn breaking.

I must go down to the seas again, for the call of the running tide
Is a wild call and a clear call that may not be denied;
And all I ask is a windy day with the white clouds flying,
And the flung spray and the blown spume, and the sea gulls crying.

I must go down to the seas again to the vagrant gypsy life,
To the gull's way and the whale's way where the wind's like a
whetted knife;
And all I ask is a merry yarn from a laughing fellow-rover,
And quiet sleep and a sweet dream when the long trick's over.

John Masefield

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House of Delegates' Action Regarding Supervision of Physician's Assistants

RICHARD H. VINCENT, *Atlanta**

At the 1978 House of Delegates meeting of the Medical Association of Georgia (MAG), action was taken defining "direct personal supervision" in connection with the use by physicians of certified physician's assistants (P.A.). A question was raised subsequently as to whether, to the extent the resolution of the MAG regarding supervision of P.A.'s is more restrictive than the existing statute and regulations governing the use of P.A.'s, a physician might be held to this higher standard of supervisory care.

Background—Existing Law and Regulations

Pursuant to the Georgia Physician's Assistant Act (the "Act"), *Ga. Code Ann.* §84-6201, *et seq.*, a P.A. is defined as "a skilled person qualified by academic and practical training to provide patients' [sic] services *not necessarily within the physical presence but under the personal direction or supervision of the applying physician.*" *Ga. Code Ann.* §84-6203(c). In addition, there are other statutory references to the fact that a P.A. is required to perform "under the direction of a physician"; *Ga. Code Ann.* §84-6206 and §84-6207(a). The specific definition of the phrase "under the direction of the physician" is not contained in the Act, but is left for the Composite State Board of Medical Examiners (the "Board") to provide.

Unfortunately, even the rules of the Board, §360-5-.01, *et seq.*, do not provide an exact definition of "direct personal supervision." Only two sections of the Board's rules shed some light on the degree of supervision which is required. First, pursuant to §360-5-.04(1), a P.A. may perform only those tasks which are specified in his or her job description then on file with and approved by the Board;† however, a proviso to this section states that tasks outside the job description may be performed by the P.A. "under the direct supervision and in the presence of the physician utilizing him." Thus, pursuant to the Board's rules, a physician is required to be present any time his or her P.A. is performing any task outside of the scope of the job description. In addition, §360-5-.07(10) restricts the use of a P.A. as follows:

> "The physician-patient relationship may not be initiated by a physician's assistant; and *except in the case of emergencies, the supervising physician must approve any diagnosis and/or treatment made and/or implemented by a physician's assistant.*" (Emphasis supplied.)

* Prepared at the request of the Medical Association of Georgia. Mr. Vincent is a partner in the firm of Powell, Goldstein, Frazer, & Murphy, General Counsel to the Association, 1100 C & S National Bank Building, Atlanta, GA 30303.

† A job description must be submitted to the Board by any physician proposing to employ a P.A. and must include the medical qualifications of the proposed P.A., a detailed description of the medical tasks to be performed by the P.A., and a general description of the physician's current practice.

In light of the requirements of the Act and the Board rules, does the Resolution create a higher standard of supervisory care? The appropriate part of the Resolution states:

> ". . . 'direct personal supervision is defined as being in the physical presence of the responsible physician or his covering physician designee on a daily basis and that all decisions regarding diagnosis or treatment must be after direct physical or phone contact with said responsible physician or his covering physician designee,' . . ."

To the extent that "direct personal supervision," as found in the Resolution, can be equated with "under the personal direction or supervision," as found in the Act, the Resolution places a more stringent supervisory duty on the physician than is required either under the Act or the Board rules in two respects: (1) the Resolution would require the P.A. to be in the physical presence of the physician on a daily basis regardless of the particulars of his job description, the existence of emergencies, etc.; and (2) despite the exception in the Board rules in the case of emergencies, the Resolution requires *all* decisions by the P.A. regarding diagnosis or treatment to be made only after direct physical or phone contact with the physician.

How Does the Resolution Affect a Physician's Civil Liability?

The basic question raised in connection with the Resolution is: Can a physician be found to be negligent in the performance of his supervisory duties if, although he has satisfied the requirements of the Act and the Board rules, he has not satisfied the more stringent requirements of the Resolution?

As a preliminary procedural matter, it appears likely that the Resolution could be introduced into evidence for a jury to consider. Although there are arguments to the contrary, such as the fact that the Resolution, as hearsay, should be excluded, the case law in Georgia appears to support the proposition that the Resolution may be introduced. In the recent Georgia case of *Queen v. Bair,* 137 Ga. App. 30 (1975), the Georgia Court of Appeals held that the plaintiff's witness, a chiropractor, could be cross-examined concerning the beliefs of other chiropractors. From this, it would seem that a physician, testifying as to the degree of supervision that is normally exercised by a physician who employs a P.A., could be cross-examined as to the Resolution, which, at least arguably, represents the beliefs of other physicians as to the degree of supervision which should be exercised by a physician over a P.A.

Once the Resolution is placed before a jury, they would consider it in light of the usual rules applicable to professional medical liability. In Georgia, "a person professing to practice surgery or the administering of medicine for compensation must bring to the exercise of his profession a reasonable degree of care and skill." *Ga. Code Ann.* §84-924. In that context, it is a question of fact for the jury to determine what is reasonable care and skill.

In Georgia, unlike other states wherein the question of what constitutes a reasonable degree of care and skill is that which is ordinarily employed by the profession *in the locality or community,* the standard is the degree of care and skill which is ordinarily employed by the profession *generally.* Thus, in *Murphy v. Little,* 112 Ga. App. 517, 145 S.E.2d 760 (1965), the Georgia Court of Appeals held that a physician who had no personal familiarity with the medical practice in Georgia was sufficiently qualified to testify as an expert as to the reasonable degree of care and skill which was ordinarily employed by the profession generally. See also, *Kenney v. Piedmont Hospital,* 136 Ga. App. 660, 222 S.E.2d 162 (1975); and *Hill v. Hospital Authority of Clarke County,* 137 Ga. App. 633, 224 S.E.2d 739 (1976). Consequently, although the Resolution may arguably represent the standard of supervision ordinarily employed in Georgia, it does not necessarily

represent the standard of supervision which is employed by the medical profession in general.

Moreover, it has been held in a long line of Georgia cases that testimony showing a mere difference in views as to the techniques employed in an operation or as to the exercise of medical judgment is insufficient to support an action for malpractice where it is shown that the opposing techniques or the opposing judgments are both acceptable and customary in the medical profession in general. See, *e.g.*, *Hayes v. Brown,* 108 Ga. App. 360, 133 S.E.2d 102 (1963). In other words, the fact that a majority of the MAG House of Delegates believes that a physician should supervise his assistant as required by the Resolution does not automatically prove that a physician who merely complies with the Act and Board rules is negligent, if the physician could show that the degree of supervision employed in the profession generally did not require the degree of supervision required by the Resolution.

In summary, the Resolution will enable plaintiff's attorneys to argue that the required standard of supervision (to avoid civil liability) is higher than required by the Act and Board rules. On the other hand, defense counsel will argue that the Resolution does not represent the views of the profession generally and is not conclusive in setting the standard. The jury must weigh the arguments and decide in each case what the standard is and whether or not it has been met.

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Extended Ambulatory Electrocardiography Experience in a Community Hospital

ROBERT B. COPELAND, M.D., and RUDENE McCOY, R.N., *La Grange**

Introduction

THE LONG-RECOGNIZED NEED for continuous electrocardiographic (ECG) recording in normally-active patients with known or suspected circulatory disorders have been substantially met by current technology. Techniques for continuous ECG recording of the ambulatory patient have evolved as a result of the ingenuity of Norman J. Holter who first developed a radiotelemetry system in 1949.[1] Miniaturized tape recorders wired to the patient and storing up to 24 hours of continuous ECG data are generally referred to as Holter Monitors. These recorders, as well as machines to rapidly scan their magnetic tapes and print out selected ECG data, are widely used. Recent articles have described the clinical perspectives and technical details of Holter Monitoring.[2, 3] The experience with this type of ECG recording of in- and out-patients at the West Georgia Medical Center in LaGrange, Georgia, is reported in this article.

Methods

At the West Georgia Medical Center, Holter Monitors are most commonly used for syncopal or near syncopal episodes, palpitations, and arrhythmias which have been recognized and need further evaluation. Other reasons include transient cerebral ischemic symptoms, unusual chest pain problems, post myocardial infarction evaluation for ischemia and ventricular ectopic activity, evaluation of pacemaker function, and evaluation of response to antiarrhythmic drugs.

Holter Monitors that store 12 or 24 hours of data are ordered through the hospital ECG Laboratory. Meticulous attention is given to technical details of positioning and attaching electrodes to minimize difficulties and artifacts with recordings. The reason for using the recorder, the patient's subjective symptoms, and medications are recorded. The patient is instructed to keep a diary and record the specific times of symptoms along with a description of associated activities. The ECG magnetic tape recordings are processed by an experienced nurse technician. These, along with the patient's diary, are then analyzed by a physician.

Results

In a review of 100 consecutive recordings done in a 2-month period, 79% were found to be abnormal (Table 1).

* Dr. Copeland is Chairman of Physician Education Committee, Georgia Heart Association. Articles for this page are prepared at the request of the Physician Education Committee of the Georgia Heart Association, Broadview Plaza, Level C, 2581 Piedmont Rd., NE, Atlanta, GA 30324.

TABLE 1

ECG Abnormalities in 100 Consecutive Patients as Recorded by Holter Monitors, West Georgia Medical Center, LaGrange

	Percent
I. Abnormality	
Paroxysmal Atrial Tachycardia	8
Paroxysmal Atrial Flutter	2
Paroxysmal Atrial Fibrillation	1
Multifocal Atrial Tachycardia	5
Intermittent Sinus Bradycardia	17
Paroxysmal Junctional Tachycardia	9
Ventricular Ectopic Beats	
Lown's Grade 1 (< 30/hr)	62
Lown's Grade 2 (> 30/hr)	17
Lown's Grade 3 (multifocal)	36
Lown's Grade 4 (coupled, Slavos)	6
Lown's Grade 5 (R on T)	6
Ventricular Tachycardia	4
Malfunctioning Pacemaker	1
2° AV Block — Mobitz Type I	2
2° AV Block — Mobitz Type II	2
3° AV Block	1
AV Dissociation	2
Intermittent Bundle Branch Block	6
Total	79*
II. No Significant Abnormalities	21

* Some patients had more than one abnormality.

Discussion

The need to establish valid associations between patient symptoms and documented cardiac arrhythmias is critical in clinical medicine. Many people, especially the elderly, who have cardiac arrhythmias are otherwise healthy.[4] Documenting the absence of cardiac abnormalities at the time symptoms are reported helps avoid unnecessary therapy and worry. We have noted, as have others, that most patients do not perceive the majority of documented ectopic beats but they usually do perceive paroxysmal arrhythmias of more than momentary duration.[5]

Obviously, there is an increased frequency of major ECG abnormalities associated with severe clinical problems. The highest percentage of life-threatening abnormalities in this series was found in patients with severe congestive heart failure, pulmonary emboli, and respiratory insufficiency. The infrequent recording of high degrees of heart block here is explained by the fact that patients presenting with these problems are admitted to an intensive care monitoring unit and often progress to pacemaker management without Holter Monitor recordings.

The usefulness of Holter Monitoring for the evaluation, treatment, and rehabilitation of patients with coronary heart disease has received much attention in the literature.[6, 7] The use of two channel recorders permits more sensitive observation of ST changes. In our experience, this has been helpful and has led to exercise stress testing when abnormalities were suggestive of ischemia in the absence of typical angina.

Several specific clinical problems are widely considered as indications for ambulatory electrocardiography. These include cardiac conduction disease,[8, 9] sick sinus or sinus node disease,[10, 11] mitral prolapse syndrome,[12, 13] Wolff-Parkinson-White Syndrome,[14, 15] prolonged QT Syndromes,[16] cardiomyopathies,[17, 18] pacemaker evaluation,[19] and chronic obstructive lung disease.[20, 21] Holter Monitors are rarely used on asymptomatic patients. Exceptions involve those patients who have had a recent myocardial infarction and who are participating in a cardiac rehabilitation program. They use the 12-hour recorders. Patients having previously

recognized cardiac arrhythmias are occasionally studied for characterization with a variety of situational stress, exercise, and drugs in an attempt to correlate cause and effect.

Many of the elderly patients presenting with symptomatic arrhythmias were found to have chronic sinoatrial disease or sick sinus syndrome. Approximately one third of the patients with permanent pacemakers were in this category. Extended ambulatory ECG monitoring has been valuable in the management of this difficult, varied, and as yet, incompletely understood syndrome.

Many arrhythmias occur for which the value of treatment remains unestablished or may be over estimated.[22, 23] It is our conclusion, however, that extended ECG recording in selected patients is of substantial, practical clinical value in a community hospital setting. The ability to evaluate an average of 100,000 consecutive ECG complexes over 24 hours in various environments, during different activities, and under varying circumstances constitutes a significant resource in clinical medicine. It not only often establishes the etiology of certain symptoms but also can be cost effective by minimizing unnecessary medications and hospitalizations. Further technical advances should make it more helpful in clinical management, more efficient, more convenient, and hopefully less costly.

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Basal Cell and Squamous Cell Carcinoma of the Skin

THOMAS A. COCHRAN JR., M.D.*

Basal cell carcinoma (BCCa) and squamous cell carcinoma (SCCa) are the most common malignancies affecting the Caucasian population. The incidence increases with age, with the first lesions appearing at about age 45. Men are affected more frequently than women. BCCa is the most common and probably accounts for 75 % of all skin cancers. SCCa is a malignancy of the keratinizing layer of the skin, and BCCa is a malignancy of the basal layer of the epidermis and the cells lining the hair follicles.[14] Some pathologists have argued that BCCa is an epithelioma and not a true malignancy. This argument is legitimate for the pathologist engaged in academic debate but is dangerous for the clinician treating the entity, since these lesions frequently show aggressive local invasion and may rarely metastasize.

Etiology

The etiology is usually the same for both BCCa and SCCa. Solar radiation is the most common causative agent, as evidenced by the increased incidence in sun-exposed parts of the body, in persons engaged in outdoor occupations, and in persons living in sunny areas.[1, 6, 14, 17]

Radiation exposure, both accidental and therapeutic, is unquestionably an important etiologic factor.[17] Many physicians and dentists acquire skin cancers after working carelessly with radiation over a number of years. Patients who have received radiation treatment for conditions such as acne or enlarged tonsils and persons who in years past received radiation to depress the thymus experience a high incidence of skin cancer at a very early age.

Chronic skin lesions, such as burn scars (or unstable scars of any type), long standing lupus, smallpox vaccination scars, and chronic granulomas predispose to BCCa and SCCa. In burn scars, BCCa develops early, and SCCa usually develops later.

Rarely, skin cancer, usually SCCa, may develop in chronic dermatoses such as psorasis, lichen planus, chronic discoid lupus, or acrodermatitis chronica atrophicans. Chronic leg ulcers, chronic hidradenitis suppurativa, and chronic draining osteomyelitis sinuses also have a significant incidence of malignant transformation. Arsenic keratosis may also develop into BCCa or SCCa.[14]

Exposure to tar, asphalt, and other aromatic hydrocarbons can lead to malignancy. They produce an inflammatory response which ultimately develops into "tar warts," which are exophytic lesions; malignancy can develop after a 20-year

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latency. Skin cancers developing from this type exposure are common on the dorsum of the foot, and these agents should be suspected when skin cancer is found in this location. When these agents are suspected, part of the treatment should be removing the exposure. This may require a change of occupation.[7]

Two other important conditions deserve consideration when discussing the etiology of skin cancer. Basal Cell Nevus Syndrome is a dominantly inherited condition affecting males and females equally. Multiple basal cell nevi develop early in life. They look like ordinary nevi or seborrheic keratoses, but microscopically they look like BCCa. The tumors are quiescent and clinically benign during early life, but at puberty there is an increase in the number of lesions and a transformation to malignancy. Other features of this syndrome are multiple sebaceous cysts, lipomas, bifid ribs, epithelial lined cysts of the jaws, calcification of the dura (especially falx cerebri), and minute pits of the palms and soles.[5, 11] The second condition, xeroderma pigmentosa, is a recessively inherited rare syndrome characterized by an abnormal sensitivity to light. The earliest symptom is hyperpigmentation of the exposed parts. Ultimately, atrophy occurs, leaving the skin wrinkled, white, and shiny, resembling chronic radio dermatitis. A young child with this syndrome may develop skin and facial features resembling a very elderly person.[12, 16] Neurologic symptoms consisting of mental retardation, cerebellar ataxia, and choreo-athetosis may develop.[16] BCCa, SCCa, and melanoma may all develop at a very early age, and the patient usually dies from one of these before age 10. Mild forms allow survival to adult life.

Diagnosis

The diagnosis of skin cancer is usually made clinically, but it can be confirmed by biopsy. The typical basal cell lesion is elevated, smooth, and shiny with well defined margins.[1] A more aggressive type, the so-called "rodent ulcer," has an ulcerated center and raised edges.† One type of BCCa that deserves special consideration is the cicatrixing or morphea-like basal cell carcinoma.[2, 13] This lesion has an advancing active margin and a burned out scarred center. It may appear clinically as only an area of scar, and it has been referred to as a self-healing lesion. In reality, it is the most aggressive type of BCCa. Biopsy of the center may show only scar; therefore, it is critical that the margin be biopsied. It is also important to remember that the spread of these lesions is three dimensional, so that tumor is probably in the base as well as in the margins of these lesions.[2, 13]

BCCa which develops in areas of chronic skin change may not have the typical appearance; the clinician should be alert to any change developing in these areas. Some BCCa are pigmented and may mimic melanoma.[1] Biopsies are mandatory if doubt exists. Biopsies may be punch, shave, incisional, or excisional. Excisional is the preferred method for small lesions.

SCCa arising de novo is usually a solitary nodule with an indurated base but often develops an ulcerative center.[1, 14] The distinction between BCCa and SCCa is often difficult but fortunately is not too critical, since the treatment is similar with the exception that the larger squamous cell lesions have a higher incidence of nodal metastasis. This is especially true of lesions of the lower lip which are almost always squamous cell and have a very high incidence of nodal metastasis (as high as 40% in some series) and of local recurrences. The location of the lesion may also be of diagnostic assistance, since 95% of BCCa and SCCa arise in sun-exposed areas, i.e. head, neck, or dorsum of the hands.[17] Skin cancers must be considered in the differential diagnosis of any chronic skin lesions, especially in a sun-exposed area. One lesion that may be especially difficult to differentiate is the keratoacanthoma. This is a self-limiting condition which clinically resembles a very aggressive squamous cell carcinoma. Keratoacanthoma is a rapidly growing elevated lesion with an ulcerated center. This lesion is classified as benign and probably resolves 100% of the time if it is indeed a keratoacanthoma.[1, 6, 14] It can be safely observed if

† In skin cancer, as in malignancies elsewhere in the body, the more exophytic the lesion, the less invasive it tends to be.

it is in an area remote from important anatomical sites such as the eye, mouth, or nose. The problem with conservative treatment in these sites is that significant tissue destruction can occur as the lesion enlarges. Even though the lesion eventually resolves it can result in significant cosmetic and functional deformity. A rational approach to treatment would be to observe the lesion until it approaches a size or location where it can no longer be treated by simple excision. Very narrow gross margins are usually adequate.

Most skin cancers have a distinct histologic appearance, but a small percent, probably less than 2%, have a mixed histologic pattern and are referred to as baso-squamous lesions. Their clinical course is that of a low-grade SCCa, and thus they can metastasize.

Even though BCCa and SCCa are rare in dark-skinned races, they have been reported and must be kept in mind.[11]

Treatment

Fortunately, the average BCCa and SCCa can be effectively controlled without danger to life, but a significant number of cases are still seen in which these tumors thwart all reasonable attempts at eradication, and eventually are fatal, usually because of intracranial extension. In others, slow progression creates widespread tissue destruction and severe functional and cosmetic deformity.[17]

BCCa and SCCa can be treated in a number of ways. Treatment with a topical agent, 5 Fluorouracil (5FU), has gained much popularity lately because of its simplicity. If it is applied in a 5% cream twice a day, most pre-malignant lesions and very superficial malignant lesions can be cured with 3 weeks of b.i.d. treatment. With prolonged treatment, larger and more aggressive lesions can be cured. It is believed that 5FU has an affinity for the altered cell, but it also affects normal cells to a degree. The ointment can be extremely irritating, and the local reaction can be quite unsightly, making the patient reluctant to appear in public. The drug must be used exactly as prescribed if maximum results are to be achieved; therefore, patient cooperation is a necessary prerequisite to successful therapy.

Local tissue destruction by electrodesiccation or freezing followed by curettage is an effective and simple treatment favored by most dermatologists. It can be used with essentially 100% success on small or superficial lesions. It works by destroying all or part of the layers of the skin.[9] The defect, like any other wound, must heal by reepithelialization or secondary intention. If larger areas are treated, significant scarring or discoloration can occur and wound contracture can produce distortion of adjacent structures. Another disadvantage of the method is the prolonged healing time which may be required if large lesions are treated. Cryosurgery should not be used in sites where major nerves lie close to the skin, because paresthesias may result. The scalp, ala nasi crease, and lower leg are sites that are relative contraindications to cryosurgery because of a high incidence of local recurrence and delayed healing.

Excision is also a very effective method of treatment.[3] Small lesions in non-critical areas can be excised without checking margins by frozen section. Uninvolved surgical margins are desirable, but tumor in the margins does not mean inevitable recurrence. BCCa recurs in about one-third of the cases (19%-67%) in which the tumor is reported in, or within one high power field, of the margin.[15] SCCa probably has a higher incidence of recurrence under this condition and should be re-excised. BCCa can be safely observed unless it is near critical structures, in which case a re-excision should be considered. Recurrence is usually apparent within 24 months. Epstein reported a 94% accuracy in visually assessing the adequacy of margins in BCCa, pointing out that the difficulty came with lesions greater than 1 cm. and with the morphea type.[8] Low-power magnifying loops can be helpful in determining the margin prior to excision, and frequently the true margin becomes more obvious after injection of the area with local anesthesia. Likewise, a glass slide pressed against the lesion may be helpful. A few millimeters of grossly normal skin usually produces clear margins in BCCa, but wider margins

should be taken if SCCa is suspected. Berne and Berne recommended a 0.5-1.0 cm. margin for nodular skin lesions and 1.0-1.5 cms. for ulcerative and morphea type lesions.[4] Critical factors such as rate of growth, location and size of the lesion, and whether or not it is primary or recurrent should also be considered when one is attempting to decide how much grossly normal tissue to include in the excision. The margins should always be checked by frozen section when dealing with large lesions, recurrent lesions, or lesions near important anatomical structures where recurrence could lead to significant deformity.

Lesions developing in burn scars should be treated early and vigorously, since the SCCa developing in this area has a high incidence of nodal metastasis and a poor prognosis once it breaks through the scar barrier. Apparently because of the scar, it is an immunologically privileged tumor until the scar is penetrated. Then, the tumor spreads almost unopposed by the normal body mechanisms.

In lesions overlying cartilage (nose or ear) serious consideration should be given to excising the underlying cartilage or at least the perichondrium. The same principal applies to lesions where the skin is in close proximity to bone.

Chemosurgery can be used effectively by dermatologists experienced in this technique. It consists of fixation of the tissue in vivo followed by sequential excision of the lesion until histologically clear margins are obtained. The technique is time consuming and complicated, so its use should be reserved for special cases. In the opinion of the author, chemosurgery's greatest value is in treating recurrent lesions adjacent to critical anatomical structures. The defects created by this technique are usually massive, since it is reserved for problem cases. The defect can be treated by allowing healing by secondary intention or by surgical closure.

Radiation therapy is another mode of treatment available for skin cancers. Both BCCa and SCCa can be effectively treated by this method, and the cure rates are probably comparable to those achieved by other methods.[1, 2] Ackerman and del Regato reported a series of 825 patients with BCCa treated with radiation.[1] They reported only 60 recurrences, of which 57 were controlled by subsequent therapy. As with other forms of treatment, radiation therapy has complications and undesirable side effects. Treatment of ulcerative lesions can result in a persistant ulcer even though the tumor is cured, or an ulcer can develop later secondary to the radiation effect. Dyschromia, conjunctival leukoplakia, and non-pliable tissue are also frequent side effects. Epiphoria can result when inner-canthus lesions are treated. Two significant disadvantages of radiation therapy are the multiple prolonged treatment regimens and the lack of knowledge concerning the margins in critical areas, such as the eye. The author prefers to reserve this mode of therapy for elderly patients or possibly other very select cases, particularly since radiation is carcinogenic and may actually complicate the problem in later years.

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Brief Summary
INDICATION: Tenuate and Tenuate Dospan are indicated in the management of exogenous obesity as a short-term adjunct (a few weeks) in a regimen of weight reduction based on caloric restriction. The limited usefulness of agents of this class should be measured against possible risk factors inherent in their use such as those described below.
CONTRAINDICATIONS: Advanced arteriosclerosis, hyperthyroidism, known hypersensitivity, or idiosyncrasy to the sympathomimetic amines, glaucoma. Agitated states. Patients with a history of drug abuse. During or within 14 days following the administration of monoamine oxidase inhibitors, (hypertensive crises may result).
WARNINGS: If tolerance develops, the recommended dose should not be exceeded in an attempt to increase the effect; rather, the drug should be discontinued. Tenuate may impair the ability of the patient to engage in potentially hazardous activities such as operating machinery or driving a motor vehicle; the patient should therefore be cautioned accordingly. *Drug Dependence:* Tenuate has some chemical and pharmacologic similarities to the amphetamines and other related stimulant drugs that have been extensively abused. There have been reports of subjects becoming psychologically dependent on diethylpropion. The possibility of abuse should be kept in mind when evaluating the desirability of including a drug as part of a weight reduction program. Abuse of amphetamines and related drugs may be associated with varying degrees of psychologic dependence and social dysfunction which, in the case of certain drugs, may be severe. There are reports of patients who have increased the dosage to many times that recommended. Abrupt cessation following prolonged high dosage administration results in extreme fatigue and mental depression; changes are also noted on the sleep EEG. Manifestations of chronic intoxication with anorectic drugs include severe dermatoses, marked insomnia, irritability, hyperactivity, and personality changes. The most severe manifestation of chronic intoxications is psychosis, often clinically indistinguishable from schizophrenia. *Use in Pregnancy*: Although rat and human reproductive studies have not indicated adverse effects, the use of Tenuate by women who are pregnant or may become pregnant requires that the potential benefits be weighed against the potential risks. *Use in Children*: Tenuate is not recommended for use in children under 12 years of age.
PRECAUTIONS: Caution is to be exercised in prescribing Tenuate for patients with hypertension or with symptomatic cardiovascular disease, including arrhythmias. Tenuate should not be administered to patients with severe hypertension. Insulin requirements in diabetes mellitus may be altered in association with the use of Tenuate and the concomitant dietary regimen. Tenuate may decrease the hypotensive effect of guanethidine. The least amount feasible should be prescribed or dispensed at one time in order to minimize the possibility of overdosage. Reports suggest that Tenuate may increase convulsions in some epileptics. Therefore, epileptics receiving Tenuate should be carefully monitored. Titration of dose or discontinuance of Tenuate may be necessary.
ADVERSE REACTIONS: *Cardiovascular*: Palpitation, tachycardia, elevation of blood pressure, precordial pain, arrhythmia. One published report described T-wave changes in the ECG of a healthy young male after ingestion of diethylpropion hydrochloride. *Central Nervous System*: Overstimulation, nervousness, restlessness, dizziness, jitteriness, insomnia, anxiety, euphoria, depression, dysphoria, tremor, dyskinesia, mydriasis, drowsiness, malaise, headache; rarely psychotic episodes at recommended doses. In a few epileptics an increase in convulsive episodes has been reported. *Gastrointestinal*: Dryness of the mouth, unpleasant taste, nausea, vomiting, abdominal discomfort, diarrhea, constipation, other gastrointestinal disturbances. *Allergic*: Urticaria, rash, ecchymosis, erythema. *Endocrine*: Impotence, changes in libido, gynecomastia, menstrual upset. *Hematopoietic System*: Bone marrow depression, agranulocytosis, leukopenia. *Miscellaneous*: A variety of miscellaneous adverse reactions has been reported by physicians. These include complaints such as dyspnea, hair loss, muscle pain, dysuria, increased sweating, and polyuria.
DOSAGE AND ADMINISTRATION: Tenuate (diethylpropion hydrochloride): One 25 mg. tablet three times daily, one hour before meals, and in midevening if desired to overcome night hunger. Tenuate Dospan (diethylpropion hydrochloride) controlled-release: One 75 mg. tablet daily, swallowed whole, in midmorning. Tenuate is not recommended for use in children under 12 years of age.
OVERDOSAGE: Manifestations of acute overdosage include restlessness, tremor, hyperreflexia, rapid respiration, confusion, assaultiveness, hallucinations, panic states. Fatigue and depression usually follow the central stimulation. Cardiovascular effects include arrhythmias, hypertension or hypotension and circulatory collapse. Gastrointestinal symptoms include nausea, vomiting, diarrhea, and abdominal cramps. Overdose of pharmacologically similar compounds has resulted in fatal poisoning, usually terminating in convulsions and coma. Management of acute Tenuate intoxication is largely symptomatic and includes lavage and sedation with a barbiturate. Experience with hemodialysis or peritoneal dialysis is inadequate to permit recommendation in this regard. Intravenous phentolamine (Regitine®) has been suggested on pharmacologic grounds for possible acute, severe hypertension, if this complicates Tenuate overdosage.

Product Information as of April, 1976

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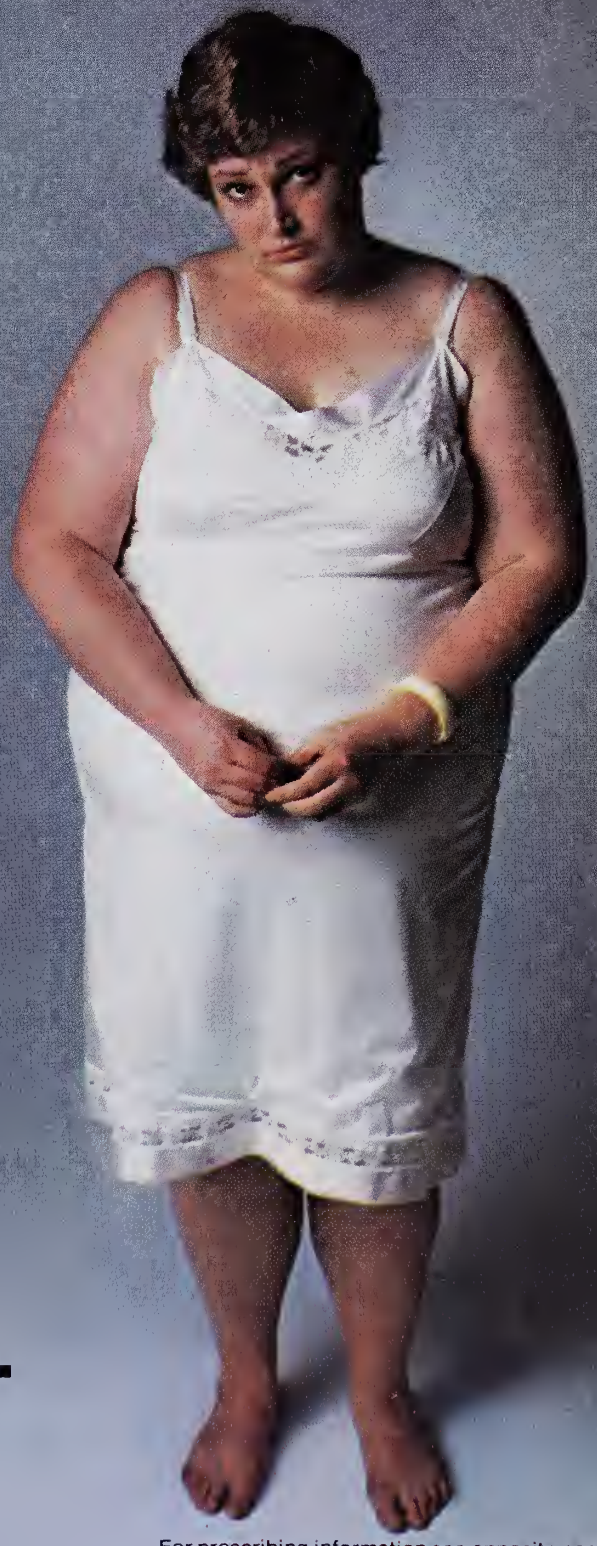
References: 1. Citations available on request—Medical Research Department, MERRELL RESEARCH CENTER, MERRELL-NATIONAL LABORATORIES, Cincinnati, Ohio 45215. 2. Hoekenga, M.T., O'Dillon, R.H., and Leyland, H.M.: A Comprehensive Review of Diethylpropion Hydrochloride. International Symposium on Central Mechanisms of Anorectic Drugs, Florence, Italy, Jan. 20-21, 1977.

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75 mg. controlled-release tablets



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Overweight patients in certain diagnostic categories often require strict obesity control. Diethylpropion hydrochloride has been reported useful in obese patients with hypertension, symptomatic cardiovascular disease, or diabetes. While it is not suggested that Tenuate in any way reduces these complications in the overweight, it may have a useful place as a short-term adjunct in a prescribed dietary regimen. (Tenuate should not be administered to patients with severe hypertension; see additional Warnings and Precautions on the opposite page.)

In uncomplicated obesity.

Many patients, on the other hand, present with excess fat but no disease. While this condition is often termed uncomplicated obesity, complications of both a social and a psychologic nature may be distressingly real for the patients. In these cases, a short-term regimen of Tenuate can help reinforce your dietary counsel during the important early weeks of an indicated weight loss program.

Clinical effectiveness.

The anorexic effectiveness of diethylpropion hydrochloride is well documented. No less than 16 separate double-blind, placebo-controlled studies attest to its usefulness in daily practice.[1] And the unique chemistry of Tenuate provides "...anorexic potency with minimal overt central nervous system or cardiovascular stimulation."[2] Compared with the amphetamines, diethylpropion has minimal potential for abuse.

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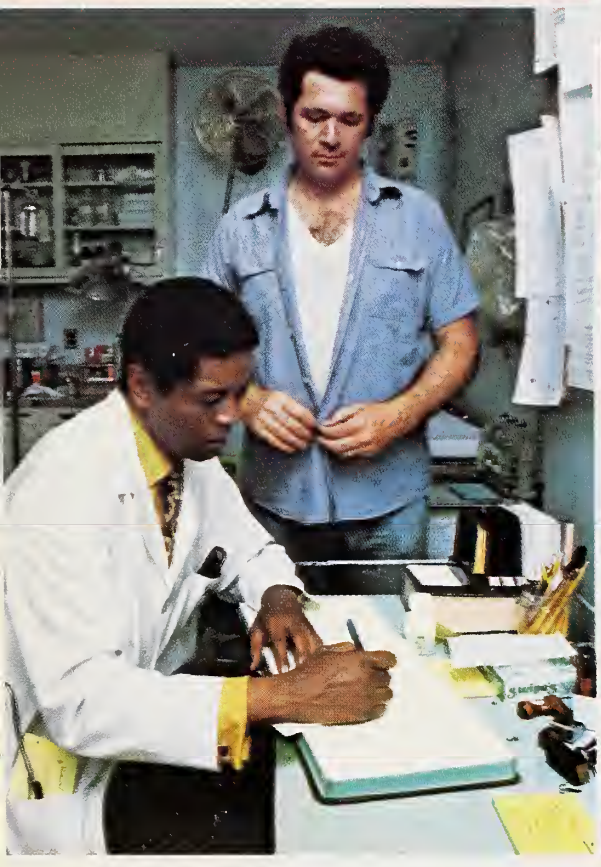
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For prescribing information see opposite page.











The evidence of experience

Since October 1974 when Motrin® (ibuprofen) was introduced in the United States, it has been used by more than 6,000,000 patients with rheumatoid arthritis* or osteoarthritis. Rarely has an ethical pharmaceutical product been prescribed for so many patients in so short a time. In addition, more than 450 studies presenting new data related to Motrin have been published.

The 6,000,000 patients already treated with Motrin is an objective measure of physicians' confidence in the ability of Motrin to relieve the pain and inflammation associated with rheumatoid arthritis and osteoarthritis.

So it is not surprising that in this short period Motrin has become the most frequently prescribed alternative to aspirin. Motrin relieves joint pain and inflammation as effectively as indomethacin or aspirin, but causes significantly fewer CNS and milder GI reactions. However, gastrointestinal bleeding, sometimes severe, has been associated with Motrin, aspirin, indomethacin, and other nonsteroidal antiarthritic agents.

*The safety and effectiveness of Motrin have not been established in patients with Functional Class IV rheumatoid arthritis (incapacitated, largely or wholly bedridden, or confined to wheelchair; little or no self-care).

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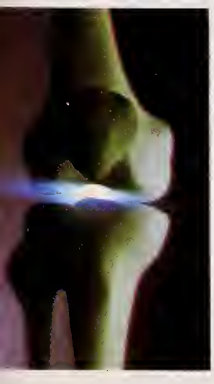












Motrin 400 mg TABLETS
ibuprofen, Upjohn

The confidence that comes from experience—one more reason to prescribe Motrin.

Please turn page for a brief summary of prescribing information.

Upjohn The Upjohn Company, Kalamazoo, Michigan 49001

J-6857-4

The confidence that comes from experience—
one more reason to prescribe

Motrin 400 mg TABLETS
ibuprofen, Upjohn

Indications and Usage: Treatment of signs and symptoms of rheumatoid arthritis and osteoarthritis during acute flares and in long-term management. Safety and efficacy have not been established in Functional Class IV rheumatoid arthritis.

Contraindications: Individuals hypersensitive to it, or with the syndrome of nasal polyps, angioedema and bronchospastic reactivity to aspirin or other nonsteroidal anti-inflammatory agents (see WARNINGS).

Warnings: Anaphylactoid reactions have occurred in patients with aspirin hypersensitivity (see CONTRAINDICATIONS).

Peptic ulceration and gastrointestinal bleeding, sometimes severe, have been reported. Ulceration, perforation, and bleeding may end fatally. An association has not been established. Motrin should be given under close supervision to patients with a history of upper gastrointestinal tract disease, only after consulting ADVERSE REACTIONS.

In patients with active peptic ulcer and active rheumatoid arthritis, nonulcerogenic drugs, such as gold, should be tried. If Motrin must be given, the patient should be under close supervision for signs of ulcer perforation or gastrointestinal bleeding.

Precautions: Blurred and/or diminished vision, scotomata, and/or changes in color vision have been reported. If these develop, discontinue Motrin and the patient should have an ophthalmologic examination, including central visual fields.

Fluid retention and edema have been associated with Motrin; use with caution in patients with a history of cardiac decompensation.

Motrin can inhibit platelet aggregation and prolong bleeding time. Use with caution in persons with intrinsic coagulation defects and those on anticoagulant therapy.

Patients should report signs or symptoms of gastrointestinal ulceration or bleeding, blurred vision or other eye symptoms, skin rash, weight gain, or edema.

To avoid exacerbation of disease or adrenal insufficiency, patients on prolonged corticosteroid therapy should have therapy tapered slowly when Motrin is added.

Drug interactions. *Aspirin* used concomitantly may decrease Motrin blood levels. *Coumarin:* Bleeding has been reported in patients taking Motrin and coumarin.

Pregnancy and nursing mothers: Motrin should not be taken during pregnancy or by nursing mothers.

Adverse Reactions

Incidence greater than 1%

Gastrointestinal: The most frequent type of adverse reaction occurring with Motrin (ibuprofen) is gastrointestinal (4% to 16%). This includes nausea*, epigastric pain*, heartburn*, diarrhea, abdominal distress, nausea and vomiting, indigestion, constipation, abdominal cramps or pain, fullness of the GI tract (bloating and flatulence). **Central Nervous System:** Dizziness*, headache, nervousness. **Dermatologic:** Rash* (including maculopapular type), pruritus. **Special Senses:** Tinnitus. **Metabolic:** Decreased appetite, edema, fluid retention. Fluid retention generally responds promptly to drug discontinuation (see PRECAUTIONS).

Incidence: Unmarked 1% to 3%; *3% to 9%.

Incidence less than 1 in 100

Gastrointestinal: Upper GI ulcer with bleeding and/or perforation, hemorrhage, melena. **Central Nervous System:** Depression, insomnia. **Dermatologic:** Vesiculobullous eruptions, urticaria, erythema multiforme. **Cardiovascular:** Congestive heart failure in patients with marginal cardiac function, elevated blood pressure. **Special Senses:** Amblyopia (see PRECAUTIONS). **Hematologic:** Leukopenia, decreased hemoglobin and hematocrit.

Causal relationship unknown

Gastrointestinal: Hepatitis, jaundice, abnormal liver function. **Central Nervous System:** Paresthesias, hallucinations, dream abnormalities. **Dermatologic:** Alopecia, Stevens-Johnson syndrome. **Special Senses:** Conjunctivitis, diplopia, optic neuritis. **Hematologic:** Hemolytic anemia, thrombocytopenia, granulocytopenia, bleeding episodes. **Allergic:** Fever, serum sickness, lupus erythematosus syndrome. **Endocrine:** Gynecomastia, hypoglycemia. **Cardiovascular:** Arrhythmias. **Renal:** Decreased creatinine clearance, polyuria, azotemia.

Overdosage: In cases of acute overdosage, the stomach should be emptied. The drug is acidic and excreted in the urine, so alkaline diuresis may be beneficial.

Dosage and Administration: Suggested dosage is 300 or 400 mg t.i.d. or q.i.d. Do not exceed 2400 mg per day.

How Supplied

Motrin Tablets, 300 mg (white)	
Bottles of 60	NDC 0009-0733-01
Bottles of 500	NDC 0009-0733-02
Motrin Tablets, 400 mg (orange)	
Bottles of 60	NDC 0009-0750-01
Bottles of 500	NDC 0009-0750-02
Unit-dose package of 100	NDC 0009-0750-06
Unit of Use bottles of 120	NDC 0009-0750-26

Caution: Federal law prohibits dispensing without prescription.

NIM-3

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Bassett, Wilbur Benson, Muscogee—N2—IM
1005 Talbotton Rd., Columbus 31904

Batra, Pramod K., Altamaha—N2—GS
210 E. Tollison St., Baxley 31513

Bergman, Bernard A., Cobb—ACT—CHP
3995 S. Cobb Dr., Smyrna 30080

Bobon, Ben L., Crawford W. Long—ACT—GP
Box 407, Statham 30666

Daniel, James S., Cobb—N2—PUD
833 Campbell Hill St., Ste. 200, Marietta 30060

Dannelly, Edward A., Crawford W. Long—N2—ORS
125 King Ave., Athens 30606

Dasgupta, Gautham, Crawford W. Long—ACT—IM
700 Oglethorpe Ave., Athens 30606

Dorsey, Harry Neil, Dougherty—ACT—IM
910 N. Jefferson, Albany 31701

Durrani, Fauzia K., South Georgia—ACT—PD
2311 N. Patterson St., Valdosta 31601

Faulkner, Ronald B., Dougherty—N2—EM
Palmyra Park Hospital, Emer. Rm., Albany 31702

Ghorashi, Bijan, Cobb—ACT—R
3865 Story Dr., SW, Marietta 30060

Gibbons, William S., Cobb—N2—ORS
211 Chicopee Dr., Marietta 30060

Griffin, Shelley Aubrey, Burke—ACT—PD
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950 W. Peachtree St., NW, Atlanta 30309

Henderson, Charles A., MAA—N2—ON
105 Collier Rd., NW, Atlanta 30309

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2131 Kingston Ct., Ste. 114, Marietta 30067

Hulse, Edwin T., Walker-Catoosa-Dade—N2—OPH
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353 Parkway Dr., NE, Atlanta 30312

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Monett, Robert, DeKalb—N1—FP
2754 N. Decatur Rd., Ste. 111, Decatur 30033

Morris, Wayne S., Crawford W. Long—N2—IM
P.O. Box 147, Athens 30604

Mullins, David E., Crawford W. Long—N1—IM
700 Oglethorpe Ave., Athens 30606

Norwood, Lyle A., Muscogee—N2—ORS
105 Physicians Bldg., Columbus 31901

Outs, Harvey, Crawford W. Long—N2—CD
700 Oglethorpe Ave., Athens 30601

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Thompson, William A., Thomas Area—ACT—OBG
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5669 Peachtree-Dunwoody Rd., NE, Atlanta 30342

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PERSONALS

First District

Curtis G. Hames, M.D., of Claxton, was honored at an Awards Banquet given by the Institutional Development Foundation of the Medical College of Georgia (MCG) in Augusta. The purpose of the Awards Banquet was to announce the Curtis G. Hames Family Practice Professorship, endowed with $250,000, to be used to benefit the Department of Family Practice at the MCG. Symbolic of the award was a medal presented to Dr. Hames with the original MCG building engraved on it. Dr. Hames stated that a professor will be employed each year on the interest from the $250,000, which will be kept intact in perpetuity.

Two Valdosta ophthalmologists, **Ben H. Moye, M.D.,** and **Tom H. Smith, Jr., M.D.,** were awarded plaques of appreciation from the Lighthouse Foundation. Drs. Moye and Smith were recognized for their work with the Foundation in giving eye examinations and performing cornea transplants.

Joe L. Nettles, M.D., a Savannah orthopedic surgeon, has been elected president of St. Joseph's medical and dental staff. Also heading the staff in 1979 will be **Franklyn P. Bousquet, M.D.,** vice-president; **Donald Wright, M.D.,** secretary; and **C. Lamont Osteen, M.D.,** treasurer. Other MAG members who were named department chiefs include **Cliff L. Cannon, M.D.,** chief of surgery; **J. A. Harris, M.D.,** chief of internal medicine; and **John L. Dekle, M.D.,** chief of obstetrics-gynecology.

Maurice Whiddon, M.D., of Savannah, has been named president of the First District Medical Society. **John L. Dekle, Jr., M.D.,** also of Savannah has taken the post of president-elect. Other officers elected were **George W. Merritt, M.D.,** of Vidalia, vice-president; **Douglas P. Cope, M.D.,** of Statesboro, secretary; **Paul Whitlock, M.D.,** of Statesboro, treasurer; **Leon E. Curry, M.D.,** director; and **C. Robert Richardson, M.D.,** alternate director to MAG's Board of Directors.

Robert A. Wynn, M.D., has been named Chief of Staff-elect of Candler Hospital in Savannah. Next year Dr. Wynn will succeed **John M. Fillingim, M.D.,** who is the Chief of Staff for 1979. Other MAG members who hold offices on the Candler medical and dental staff include **Wesley J. Ball, M.D.,** secretary; **Thomas L. German, M.D.,** treasurer; and **Edgar Filson, M.D.,** immediate past Chief of Staff. **Daniel W. Rose, M.D., Dan H. Willoughby, M.D.,** and **Julian K. Quattlebaum, Jr., M.D.,** have been named executive committee members-at-large. The department chairmen for 1979 are **Max L. Clayton, M.D.,** anesthesiology; **George Haberman, M.D.,** emergency; **Fred Kessler, Jr., M.D.,** family practice; **Harry Rollings, M.D.,** medicine; **David W. Fillingim, M.D.,** obstetrics-gynecology and pediatrics; **Frank Hoffman, M.D.,** eyes, ears, nose and throat; **Roderick L. Guerry, M.D.,** pathology; **Gordon C. Carson, M.D.,** radiology; and **Thomas R. Freeman, M.D.,** surgery.

Second District

Edwin E. Flournoy, M.D., of Albany, has been appointed chairman of the Committee on Constitution and Bylaws of the American Academy of Family Physicians.

Third District

James G. Herron, M.D., from Americus, was honored by the Americus and Sumter County Hospital on his retirement as Chief of Medical Staff following a 2-year term. Dr. Herron now becomes staff vice chairman as **T. J. Rundle, M.D.** takes his place as Chief of Staff. **Henry Teaford, M.D.,** has been named secretary-treasurer of the hospital staff.

Fifth District

The Georgia Baptist Medical Center's Medical Staff in Atlanta has elected and installed their officers for the new year. They are: **William D. Logan, Jr., M.D.,** president; **Charles Scott, Jr., M.D.,** president-elect; **Edwin C. Evans, M.D.,** secretary; **Charles F. Nicol, M.D.,** representative to the Executive Committee; and **Richard E. DuBois, M.D.,** chief of staff. MAG members who were appointed department chairmen include: **Julius N. Hill, III, M.D.,** anesthesiology; **David M. Taylor, M.D.,** internal medicine; **Philip I. Krugman, M.D.,** obstetrics-gynecology; **Charles I. Hancock, M.D.,** orthopedics; **Robert E. DeLashmutt, M.D.,** pathology; **Alfred Joseph, M.D.,** pediatrics; **Ross F. Grumet, M.D.,** psychiatry; and **Grover L. Anderson, M.D.,** surgery.

William D. Logan, M.D., of Atlanta, has been appointed Governor of the American College of Chest Physicians and was recently named Vice President of the Southern Thoracic Surgical Association.

Paul Stanton, M.D., Atlanta, was guest lecturer at an international seminar on stroke research in London. Dr. Stanton also lectured at Oxford University in England, the Society of Vascular Surgeons in Los Angeles, and the American College of Surgeons post-graduate course on vascular surgery in San Francisco. His subject was carotid kinks.

J. Hiram Kite, M.D., a Decatur orthopedic surgeon for the past 50 years, received an award from the Southern Medical Association at the SMA-MAG Scientific Assembly. Dr. Kite was cited as "an outstanding leader in southern medicine and orthopedic surgery" and "for his dedication and many contributions to the SMA and the handicapped child."

Charles R. Hatcher, Jr., M.D., J. Willis Hurst, M.D., and **Spencer King, M.D.,** of Atlanta, were featured speakers at an Emory Medical Center Update for the news media. They discussed the benefits and drawbacks of surgical and non-surgical methods of treating heart disease.

Richard W. Blumberg, M.D., professor and chairman of the Department of Pediatrics, Emory University School of Medicine, has received the first Katharine Dodd Award in recognition of his outstanding achievements in pediatrics in Atlanta. The award was presented by **Gerald T. Zwiren, M.D.,** president of the Greater Atlanta Pediatric Society. The award was named for the late Katharine A. Dodd, M.D., a pediatrics faculty member at Vanderbilt and Emory before her death in 1965.

Seventh District

Mark Gould, M.D., medical director of Brawner Psychiatric Institute in Smyrna, was elected Vice-Chairman of the National Association of Private Psychiatric Hospitals at the 46th annual meeting held in Marco Beach,

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Florida. Dr. Gould also assumed office, January 1, as chairman of the Accreditation Council for Psychiatric Facilities for the Joint Commission on Accreditation of Hospitals.

William Harbin, M.D., was named Doctor of the Year by the Rome Chapter of the American Association of Medical Assistants at their annual installation and awards banquet.

Mitchell Jablow, M.D., has been appointed chief of the medical staff at Urban Medical Hospital in Marietta.

Robert Norton, M.D., 69, of Rome, officially retired January 1, after a career in obstetrics-gynecology in Floyd County.

General practitioner, **J. LeRoy Rabb, M.D.,** Calhoun, has been named chief of the medical staff at Gordon Hospital.

Judson R. Trippe, Jr., M.D., a Marietta pediatrician, spoke to members of the West Side Elementary School PTA during a meeting in their regular series of educational study courses.

Eighth District

Jerry G. Purvis, M.D., Valdosta, has been installed as Chief of Staff of South Georgia Medical Center for 1979. Dr. Purvis succeeds **Robert Quattlebaum, M.D.,** who served as chief in 1978. **Mack V. Greer, M.D.,** was chosen as Chief of Staff-Elect. Other officers elected to the staff include **Charles O. Barker, M.D.,** secretary-treasurer; **William R. Grow, M.D.,** executive committee member-at-large; **Earl L. Creech, M.D.,** chairman of the Department of Surgery; and **Gerald S. Light, M.D.,** chairman of the Department of Medicine.

Ninth District

Daniel Luke, M.D., a Gainesville physician, has successfully completed requirements for certification as a family practitioner.

L. N. Turk, Jr., M.D., retired December 31 for a second time. Dr. Turk retired from Atlanta to Homer 18 years ago but found his services so much in demand in Homer that he began work again. He is 80 years old and has practiced medicine for 51 years.

SOCIETIES

Charles R. Hatcher, Jr., M.D., of Atlanta, the **American College of Cardiology** (ACC) Governor for Georgia, has announced that the following MAG members have achieved the rank of fellowship in the ACC. They are: Richard A. Bardack, M.D., Marietta; Jerome B. Blumenthal, M.D., Marietta; Richard N. Smith, M.D., Atlanta; and Robert L. Whipple, III, M.D., Atlanta.

At their December meeting the members of the **Ware County Medical Society** in Waycross saw a film entitled, "Renal Stone Management." It was presented by Mr. Marvin Bailey of Burroughs-Wellcome.

DEATHS

H. Homer Allen

H. Homer Allen, who practiced medicine in Decatur for 43 years, died Tuesday, January 2, 1979, at the age of 82.

A native of Russell County, Alabama, Dr. Allen attended Mercer University and Emory University at Oxford, before graduating from Emory University School of Medicine in 1926. He interned at Grady Memorial Hospital and St. Luke's Hospital in Bethlehem, Pennsylvania, before opening his private practice in Decatur in 1928.

In 1958, he was appointed by the DeKalb County Medical Society as chairman of the medical advisory committee for DeKalb General Hospital. Dr. Allen attended the first medical staff meeting after the hospital opened in 1961 and was later elected president of the staff and served on the executive committee. He was a past president of the medical staff of Emory University Hospital and served on the staffs of Henrietta Egleston Hospital and Georgia Baptist Hospital. He was a member of the DeKalb County Medical Society, the Medical Association of Georgia, the Southern Medical Association, and the American Medical Association. He was a U.S. Army veteran of World War I and a member of the Decatur Civitan Club.

Survivors include his wife, Mrs. Arline A. Allen, a daughter, a son, and two sisters. In lieu of flowers, contributions may be made to the Dr. H. Homer Allen Medical Scholarship Endowment Fund, in care of the Treasurer's Office of Emory University.

James E. Cantrell

James E. Cantrell, 58, of East Point, died Tuesday, January 2, 1979. He was a graduate of Emory University and the Medical College of Georgia. Dr. Cantrell served on the medical staff at South Fulton Hospital and was a member of the Medical Association of Atlanta and the Medical Association of Georgia. He was also a member of the Elks Club. Born in Oakfield, Georgia, Dr. Cantrell served in the U.S. Navy Medical Corps during World War II and received the Purple Heart.

Survivors include his wife, Mrs. Jane Cantrell, 3 daughters, a son, his mother, and a brother. Contributions may be made to Brewton-Parker Junior College, Mount Vernon, Georgia.

Evelyn Swilling

Evelyn Swilling, M.D., 71, of Macon, died January 17, 1979, after a long illness. She was born in Suwanee, Georgia. She was a graduate of the University of Georgia, the Medical College of Georgia, and did post graduate study at the University Hospital.

Dr. Swilling practiced in Macon from 1934 until her retirement in 1973. She was a member of the Bibb County Medical Society, the American Medical Association, the Medical Association of Georgia, and the South Atlantic Association of Obstetrics and Gynecology. She was also a member of the Middle Georgia Camelia Society.

Survivors include two aunts.

Fred P. Manget

Fred P. Manget, M.D., of Macon-Atlanta, died January 21, 1979, at the age of 99. Born in Marietta, Dr. Manget received his M.D. degree from Emory University and after completing his residency and internship training, went to China as a Methodist medical missionary in 1909. Stationed in Huchow, he worked there until the communist takeover in 1949. He was responsible for building a 60-bed hospital and later a 200-bed hospital. In 1918, Dr. Manget went with a volunteer unit and ministered to Russian prisoners in Siberia. There he met Robert Scott of Macon and inspired the best-selling book and movie *God Is My Co-Pilot*.

Dr. Manget returned to the United States in 1950. In 1953 he was granted a permit to open a free medical clinic for the poor in Atlanta. An average of 80 to 100 patients were seen daily until the clinic closed in 1959. In the same year Dr. Manget married his second wife, Jennie Layall, and moved to Macon. There he gave free medical assistance and medicine to elderly, house-bound patients served by the Bibb County Department of Family and Children services. At 95, he was still volunteering several days a week to tend the sick. He received MAG's Civic Endeavor Award in April 1976. Through it all he shared the love and light of his faith with those either physically or spiritually in need.

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State Medical Journal Editors Attend Journalism Workshop

A medical journalism workshop was held in Chicago on January 20, 1979, and Susan Dillon, managing editor of the *Journal of the Medical Association of Georgia,* and Custer Holliday (right), executive director of the *Journal of the West Virginia Medical Association,* were among 20 of the participants. Blake Kellogg (left), professor of journalism at the University of Wisconsin, discussed the need for simplified language in journals and other publications.

The meeting, conducted by Sandoz Pharmaceuticals, was part of a year-round program to provide design and writing help to the editors of state medical and pharmaceutical journals.

Other southern editors at the workshop were from the medical associations of Florida and Tennessee, and the pharmaceutical associations of Florida and Georgia. They deserve special commendation for going to Chicago a few days after a record-breaking snow storm. Speakers at the meeting were Professor Kellogg; Paul Fisher, professor of journalism at the University of Missouri, and Richard Weiner, public relations counsel to Sandoz Pharmaceuticals.



Blake Kellogg (l), Susan Dillon, and Custer Holliday attend Sandoz workshop for editors of state medical journals.

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Physician's Recognition Award Recipients

LISTED BELOW *are those physicians in Georgia who have earned the AMA's Physician's Recognition Award from July through September 1978.*

The award was established in 1969 "to recognize, encourage and support physicians who participate regularly in continuing medical education and to emphasize the importance of developing more meaningful continuing medical education opportunities for physicians." A minimum of 150 credit hours of CME must be earned over a three-year period to qualify for the award. The hours may include such activities as conferences, residencies, teaching, writing, private reading, listening to cassettes, home study courses, consultation, and peer review; at least 60 of the hours, however, must be from formal CME programs sponsored or co-sponsored by organizations accredited for these activities.

We congratulate the following physicians who have distinguished themselves and their profession by their commitment to continuing education:

Hans Werner Adams, Macon
Juan Jeronimo Aguilar, Milledgeville
George Oren Atkinson, Atlanta
Pedro Luis Benitez, Savannah
Belford C. Blaine, Atlanta
Marvin Blase, Atlanta
William Hautman Bridges, Albany
George Willcox Brown, Griffin
Ruth Cardwell Brown, Atlanta
Ricardo B. Cansino, Fort Gordon
James Milton Carico, Thomasville
Robert Eugene Cato, Macon
Charles Di Liberti, Macon
Richard E. DuBois, Atlanta
James Crawford Dudley, Americus
William Hugh Earley, Gainesville
Jack Ronald Edgens, Rome
Robert L. Egan, Atlanta
Taher Abdel M. El Gammal, Augusta
Goodman Basil Espy, Marietta
William Alois Fajman, Atlanta
Robert Allen Fine, Atlanta
Miguel Alberto Fonseca, Savannah
John Phillip Gingrey, Marietta
Hamlin Graham, Augusta
William Lee Graham, Columbus
Ray Groover, Americus
Hector P. Gutierrez, Savannah
Howard Kenton Hamilton, McCaysville
William E. Harden, Brunswick
Jesse Drake Hester, Tifton
Thomas Avery Hetherington, Savannah
Gordon Lawrence Hixson, Fort Oglethorpe
Robert H. Holmes, Dunwoody
Jerry Wayne Howington, Augusta
Dorothy S. Jaeger-Lee, Atlanta
Jimpsey B. Johnson, Augusta
Milton Joseph Jolivette, Fort Benning
Alvin D. Josephs, Atlanta
Henry Slater Kahn, Atlanta
Alan Barry Kantsiper, Athens
Clifford McCord Kerley, Decatur
Daniel Lee Kingloff, Atlanta
Ronald Howard Koenig, East Point
Robert Mark Kolodner, Decatur
Robert Matthew Levy, Riverdale
William Henry Lippitt, Savannah
James Harvey Litton, Jonesboro
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James Alan Miller, Savannah
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William Joseph Morton, Cairo
William R. Murphy, Augusta
Ellis Harold Nelson, Augusta
Fred L. Nelson, Nashville
Phillip Irwin Nieburg, Atlanta
Charles Edwin Nuttall, Rome
James Lawton O'Quinn, Augusta
Edward D. Piatt, Savannah
Ermete E. Pierleoni, Alto
David Rimland, Decatur
Millard Irvin Ross, Atlanta
Khalid Saeed, Elberton
John R. Satterthwaite, Augusta
Hyun Chul Shin, Albany
Robert Daniel Shuman, Dublin
Marvin Eugene Skelton, St. Simons Island
Alfredo E. Suarez, Baxley
Grace L. Tarrant, Macon
David C. Thibodeaux, Marietta
Frederick Alan Trest, Augusta
Dominiciano A. Valbuena, Savannah
Charles William Walden, Decatur
James Edward Washington, Atlanta
Caroline J. Williams, Savannah

Institute of Aging Established in Augusta

The Augusta Institute of Aging, a joint venture of Augusta College, Paine College, and the Medical College of Georgia, has been formed. The purpose of the Institute is to coordinate education, research, and training in the field of aging, according to Dr. Burley, assistant professor of sociology at Augusta College and newly appointed executive director of the Institute. The Institute will provide an organizational structure for individuals, service-delivery organizations, governmental agencies, and educational institutions in the Augusta area that are interested in gerontology and geriatrics. It will offer workshops in various parts of Augusta to provide in-service training for people in nursing homes, will sponsor pre-retirement workshops, and will offer a workshop in Introduction to Elderly Care this summer.

Dr. Burley offered the following statistics: In the United States, there are 22 million people 65 years or over, 10 million over 73, 1 million over 85, and 106,000 over 100. The 75 and over age group is the fastest growing segment in the U.S. population. Our most important job, he said, is to instruct the community in what to expect — both physically and psychologically from the aging process.

I've told this before . . .

Tired of Living — Afeard of Dying

ONE OF THE first calls I received after I started practicing medicine was from a neighbor calling on behalf of the town's character, John Henry. John Henry eeked out a living hawking roasted and boiled peanuts, candy bars, fruit, shoe laces, etc., from a side-walk stand. He was a hypochondriac and often gained the sympathy of his customers as he regaled them with vivid descriptions of the aches and pains that afflicted him from the top of his head to the end of his toes. His most common complaint was about his "rheumatiz."

I thanked the neighbor for calling, and drove over to John Henry's home. As I got out of my car, I could hear him wailing, "Lord, send Your angel, Gabriel, down here to carry me to Your heavenly home! I can't stand my miseries any longer!" I knocked on the door.

John Henry, who didn't know a doctor had been called, asked, "Who's that?"

In my best angelic voice, I replied, "John Henry, I am the Lord's angel, come to take you to His heavenly home."

John answered in a panicky voice, "I don't know you! Get away from here — right now! And don't you come back!"

J. Morgan Kellum, M.D.
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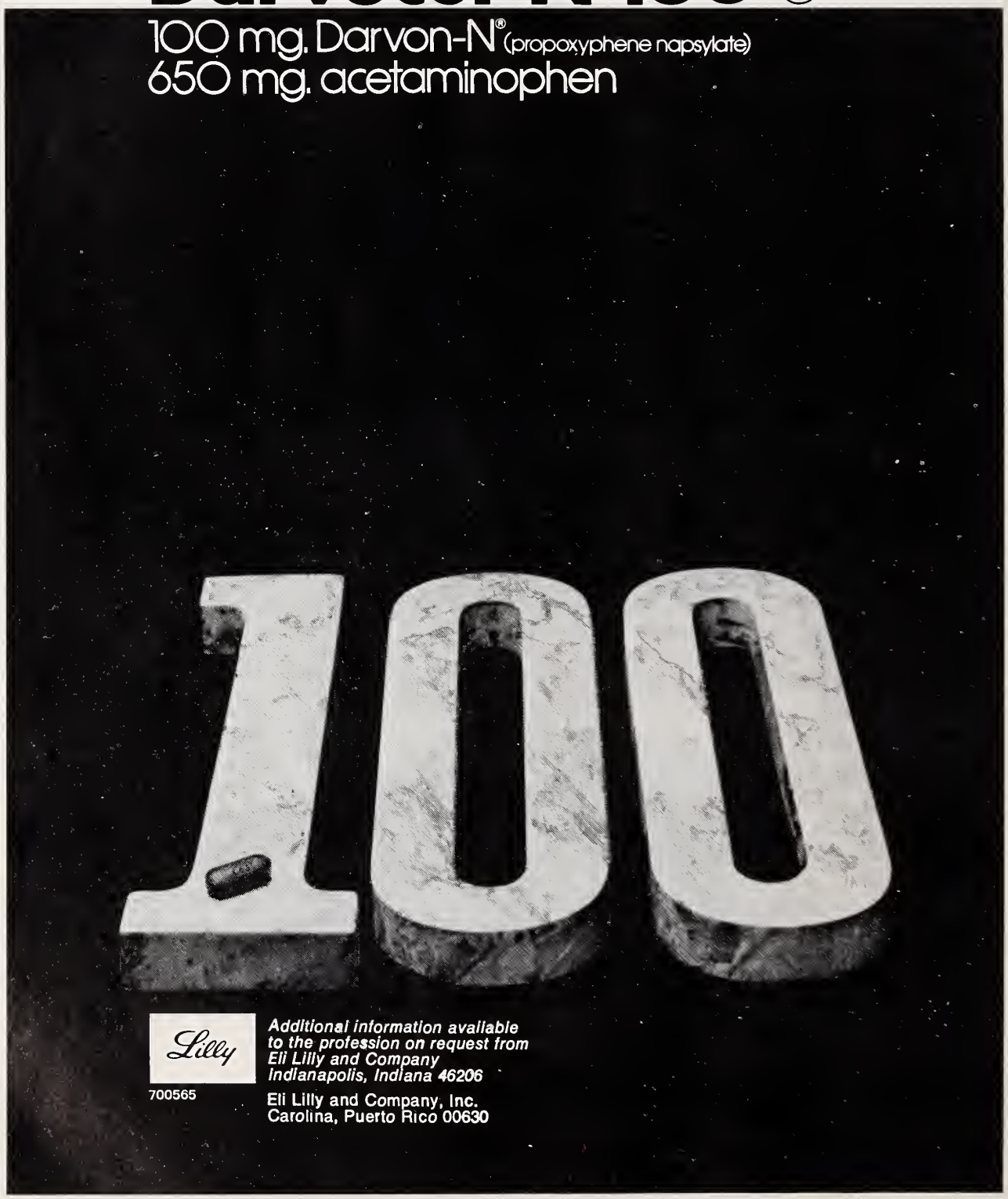
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MISCELLANEOUS

THE GEORGIA AGRIRAMA, a non-profit State of Georgia funded restoration project of late nineteenth century life in Georgia, is in need of information, artifacts, books, etc. dealing with the practice of medicine during the time period 1870-1899. Interested parties should contact: Georgia Agrirama, P.O. Box Q, Tifton, GA 31794; (912) 386-3344. Donations are tax deductible.

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ete information or a personal tour of the facilities and explanation of programs, contact:

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STYLE — Ordinarily articles should not exceed 3,000 words. Only under exceptional circumstances will articles of over 4,000 words be published. Footnotes, bibliographies, and legends should be typed on separate sheets, double-spaced. Bibliographies should conform to the following style: name of author (with initials), title of article, name of periodical, volume (number, if available), pages, date. Example (1) **(Note punctuation):** Jones SR, Smith JT, Burns EC: The study of diabetes mellitus in middle-aged women. N Engl J Med 8(2):225-227, December 1977. Example (2): Gordon ME, Johnson MT, Doerr, JD, et al.: Smoking as a contraindication to the prescription of oral contraceptives. JAMA 10:17-18, 1978, Jan. 8, 1978.

NEWS NOTES — District and county medical societies, Association members, and readers are invited to send in any news items of general concern to members of the Medical Association of Georgia.

REPRINTS — Requests for reprints should be made directly to The Ovid Bell Press, Inc., 1201-05 Bluff Street, Fulton, Missouri 65251. Reprints must be ordered within 30 days after publication, since all type will be destroyed after that time.

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Warnings: Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been associated with sulfonamides. Experience with trimethoprim is much more limited but occasional interference with hematopoiesis has been reported as well as an increased incidence of thrombopenia with purpura in elderly patients on certain diuretics, primarily thiazides. Sore throat, fever, pallor, purpura or jaundice may be early signs of serious blood disorders. Frequent CBC's are recommended; therapy should be discontinued if a significantly reduced count of any formed blood element is noted.

Precautions: Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, severe allergy or bronchial asthma. In patients with glucose-6-phosphate dehydrogenase deficiency, hemolysis, frequently dose-related, may occur. During therapy, maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function.

Adverse Reactions: All major reactions to sulfonamides and trimethoprim are included, even if not reported with Bactrim. *Blood dyscrasias:* Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia. *Allergic reactions:* Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis. *Gastrointestinal reactions:* Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, diarrhea and pancreatitis. *CNS reactions:* Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness. *Miscellaneous reactions:* Drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L. E. phenomenon. Due to certain chemical similarities to some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia in patients; cross-sensitivity with these agents may exist. In rats, long-term therapy with sulfonamides has produced thyroid malignancies.

Dosage: Not recommended for infants less than two months of age.

Urinary Tract Infections: Usual adult dosage—1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 10-14 days.

Recommended dosage for children—8 mg/kg trimethoprim and 40 mg/kg sulfamethoxazole per 24 hours, in two divided doses for 10 days. A guide follows:

Children two months of age or older:

Weight		Dose—every 12 hours	
lbs	kgs	Teaspoonfuls	Tablets
20	9	1 teasp. (5 ml)	½ tablet
40	18	2 teasp. (10 ml)	1 tablet
60	27	3 teasp. (15 ml)	1½ tablets
80	36	4 teasp. (20 ml)	2 tablets or 1 DS tablet

For patients with renal impairment:

Creatinine Clearance (ml/min)	Recommended Dosage Regimen
Above 30	Usual standard regimen
15-30	½ the usual regimen
Below 15	Use not recommended

Pneumocystis carinii pneumonitis: Recommended dosage: 20 mg/kg trimethoprim and 100 mg/kg sulfamethoxazole per 24 hours in equal doses every 6 hours for 14 days. See complete product information for suggested children's dosage table.

Supplied: *Double Strength (DS) tablets,* each containing 160 mg trimethoprim and 800 mg sulfamethoxazole, bottles of 100; Tel-E-Dose® packages of 100. *Tablets,* each containing 80 mg trimethoprim and 400 mg sulfamethoxazole—bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 40, available singly and in trays of 10. *Oral suspension,* containing in each teaspoonful (5 ml) the equivalent of 40 mg trimethoprim and 200 mg sulfamethoxazole, fruit-licorice flavored—bottles of 16 oz (1 pint).

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Please see next page.

Her next attack of cystitis may require

the Bactrim™ 3-system counterattack



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Bactrim has shown high clinical effectiveness in recurrent cystitis as a result of its wide spectrum and distinctive antimicrobial action in the urinary, vaginal and lower intestinal tracts.

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Bactrim fights uropathogens in the urinary tract/vaginal tract/lower intestinal trac

Please see reverse side for summary of product information.

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An Epidemiologic View Of Legionnaires' Disease

PEDIATRIC INDICATIONS* FOR BACTRIM CONTINUE TO GROW...

URINARY TRACT INFECTIONS

PNEUMOCYSTIS CARINII PNEUMONITIS

SHIGELLOSIS

ACUTE OTITIS MEDIA

*Involving susceptible organisms.

Please see Indications section in summary of product information on last page of this advertisement.

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(Prescription for a 10-kg [22-lb] child)

Be sure to specify

*ESPECIALLY FLAVORED FOR CHILDREN**

Also available: The original fruit-licorice flavor to be prescribed as "Bactrim Suspension." The same active ingredient formulation—the difference is the flavor.

*Contraindicated in children under 2 months of age.

Please see summary of product information on following page.

BACTRIM™

(trimethoprim and sulfamethoxazole)

ROCHE

Before prescribing, please consult complete product information, a summary of which follows:

Indications and Usage: For the treatment of urinary tract infections due to susceptible strains of the following organisms: *Escherichia coli, Klebsiella-Enterobacter, Proteus mirabilis, Proteus vulgaris, Proteus morganii.* It is recommended that initial episodes of uncomplicated urinary tract infections be treated with a single effective antibacterial agent rather than the combination. *Note* The increasing frequency of resistant organisms limits the usefulness of all antibacterials, especially in these urinary tract infections **For acute otitis media in children due to susceptible strains of *Haemophilus influenzae* or *Streptococcus pneumoniae* when in physician's judgment it offers an advantage over other antimicrobials. Limited clinical information presently available on effectiveness of treatment of otitis media with Bactrim when infection is due to ampicillin-resistant *Haemophilus influenzae*. To date, there are limited data on the safety of repeated use of Bactrim in children under two years of age. Bactrim is not indicated for prophylactic or prolonged administration in otitis media at any age.**
For enteritis due to susceptible strains of *Shigella flexneri* and *Shigella sonnei* when antibacterial therapy is indicated.
Also for the treatment of documented *Pneumocystis carinii* pneumonitis. To date, this drug has been tested only in patients 9 months to 16 years of age who were immunosuppressed by cancer therapy.
Contraindications: Hypersensitivity to trimethoprim or sulfonamides, pregnancy; nursing mothers, infants less than two months of age
Warnings: BACTRIM SHOULD NOT BE USED TO TREAT STREPTOCOCCAL PHARYNGITIS. Clinical studies show that patients with group A β-hemolytic streptococcal tonsillopharyngitis have higher incidence of bacteriologic failure when treated with Bactrim than do those treated with penicillin. Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been associated with sulfonamides. Experience with trimethoprim is much more limited but occasional interference with hematopoiesis has been reported as well as an increased incidence of thrombopenia with purpura in elderly patients on certain diuretics, primarily thiazides. Sore throat, fever, pallor, purpura or jaundice may be early signs of serious blood disorders. Frequent CBC's are recommended; therapy should be discontinued if a significantly reduced count of any formed blood element is noted
Precautions: Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, severe allergy or bronchial asthma. In patients with glucose-6-phosphate dehydrogenase deficiency, hemolysis, frequently dose-related, may occur. During therapy, maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function. Bactrim may prolong prothrombin time in those receiving warfarin; reassess coagulation time when administering Bactrim to these patients.
Adverse Reactions: All major reactions to sulfonamides and trimethoprim are included, even if not reported with Bactrim. *Blood dyscrasias:* Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia. *Allergic reactions:* Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis. *Gastrointestinal reactions:* Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, diarrhea and pancreatitis. *CNS reactions:* Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness. *Miscellaneous reactions:* Drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L.E. phenomenon. Due to certain chemical similarities to some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia in patients; cross-sensitivity with these agents may exist. In rats, long-term therapy with sulfonamides has produced thyroid malignancies.
Dosage: Not recommended for infants less than two months of age.
URINARY TRACT INFECTIONS AND SHIGELLOSIS IN ADULTS AND CHILDREN, AND ACUTE OTITIS MEDIA IN CHILDREN
Adults: Usual adult dosage for urinary tract infections—1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 10-14 days. Use identical daily dosage for 5 days for shigellosis
Children: Recommended dosage for children with urinary tract infections or acute otitis media—8 mg/kg trimethoprim and 40 mg/kg sulfamethoxazole per 24 hours, in two divided doses for 10 days. Use identical daily dosage for 5 days for shigellosis. A guide follows:
Children two months of age or older

Weight		Dose—every 12 hours	
lbs	kgs	Teaspoonfuls	Tablets
22	10	1 teasp. (5 ml)	½ tablet
44	20	2 teasp. (10 ml)	1 tablet
66	30	3 teasp. (15 ml)	1½ tablets
88	40	4 teasp. (20 ml)	2 tablets or 1 DS tablet

For patients with renal impairment:

Creatinine Clearance (ml/min)	Recommended Dosage Regimen
Above 30	Usual standard regimen
15-30	½ the usual regimen
Below 15	Use not recommended

PNEUMOCYSTIS CARINII PNEUMONITIS. Recommended dosage: 20 mg/kg trimethoprim and 100 mg/kg sulfamethoxazole per 24 hours in equal doses every 6 hours for 14 days. See complete product information for suggested children's dosage table
Supplied: *Double Strength (DS) tablets*, each containing 160 mg trimethoprim and 800 mg sulfamethoxazole, bottles of 100; Tel-E-Dose® packages of 100; Prescription Paks of 20. *Tablets*, each containing 80 mg trimethoprim and 400 mg sulfamethoxazole—bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 40, available singly and in trays of 10. *Pediatric Suspension*, containing in each teaspoonful (5 ml) the equivalent of 40 mg trimethoprim and 200 mg sulfamethoxazole, cherry flavored—bottles of 16 oz (1 pint). *Suspension*, containing in each teaspoonful (5 ml) the equivalent of 40 mg trimethoprim and 200 mg sulfamethoxazole, fruit-licorice flavored—bottles of 16 oz (1 pint)

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April, 1979 Meetings

April 4–7 **Tennessee Medical Association**
Airport Milton Inn
Memphis, Tennessee

April 19–21 **Alabama Medical Association**
Birmingham Hyatt House, Civic Center
Birmingham, Alabama

April 19–22 **Missouri State Medical Association**
Chase-Park Plaza Hotel
St. Louis, Missouri

April 20–22 **Georgia Medical Association**
De Soto Hilton
Savannah, Georgia

April 21–22 **Iowa Medical Society**
Hyatt House
Des Moines, Iowa

April 22–25 **Arkansas Medical Society**
Little Rock Convention Center
Little Rock, Arkansas

April 25–29 **Arizona Medical Association**
Safari Hotel
Scottsdale, Arizona

April 26–29 **South Carolina Medical Association**
Myrtle Beach Hilton
Myrtle Beach, South Carolina

April 29–
May 2 **Nebraska Medical Association**
Holiday Inn
Kearney, Nebraska

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THE COVER

Details of the once-elusive Legionnaires' Disease bacteria *(Legionella pneumophila)* grown in Mueller-Hinton broth are dramatically highlighted in this electron micrograph, × 75,000. Note division by central pinching and enclosure of bacteria by a double envelope — characteristic features of gram-negative bacteria (uranyle acetate and lead citrate). Photo courtesy of Dr. Francis W. Chandler Jr., Pathology Division, Center for Disease Control. Cover design by Richard Lyons of TFC.

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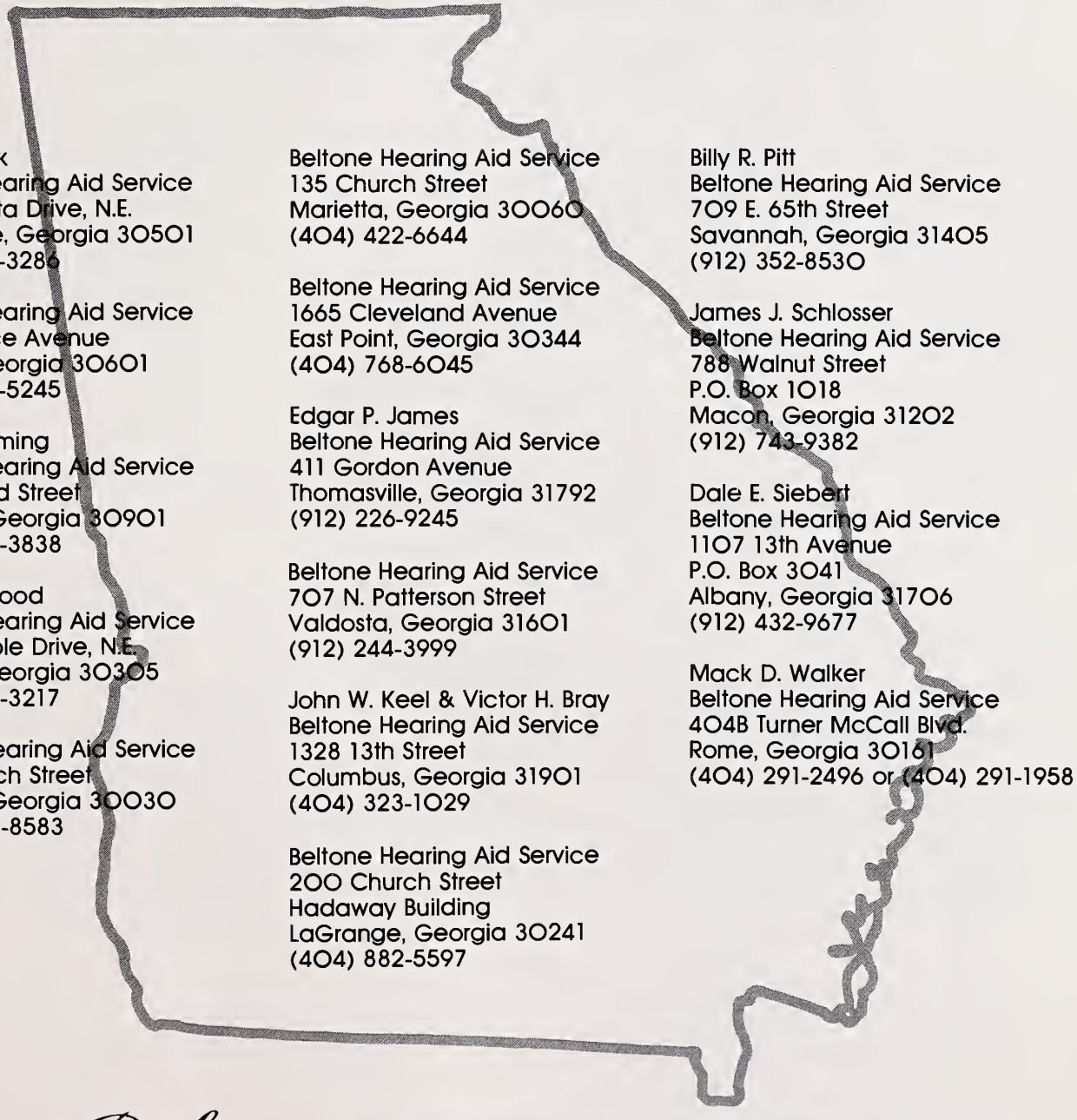
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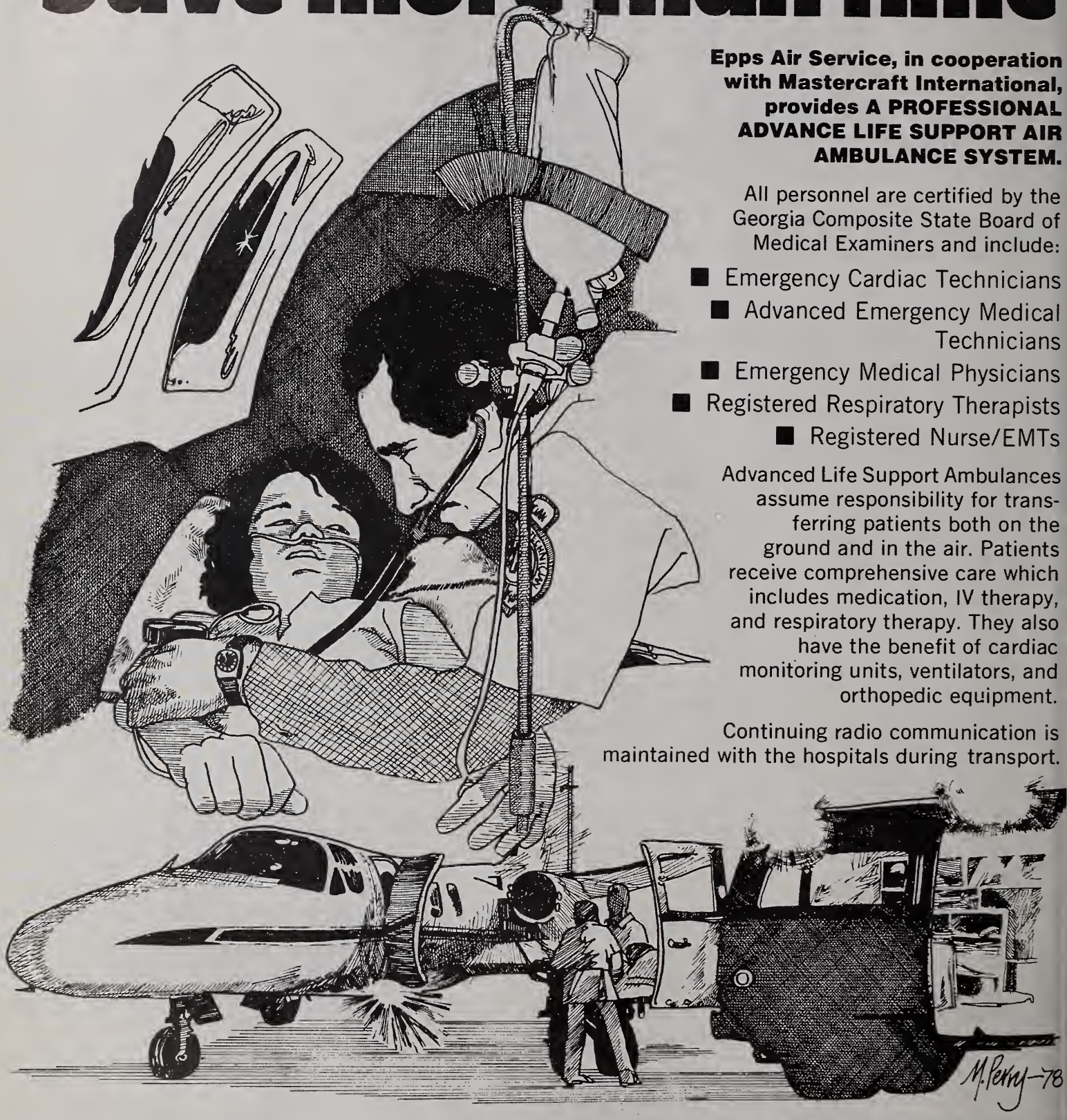
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MEDICAL MEETING CALENDAR

APRIL

27—*Atlanta;* **FIRST ANNUAL UPDATE — GASTROENTEROLOGY;** Category 1 credit; Contact: Office of Continuing Education, Georgia Baptist Medical Center, 300 Boulevard, N.E., Atlanta 30312. PH: 404/659-4211, ext. 2346.

27-29—*Columbia, SC;* **CLINICAL EKG ARRHYTHMIA MANAGEMENT;** Contact: International Medical Education Corp., 64 Inverness Dr. East, Englewood, CO 80110.

28—*Atlanta;* **NARCISSISTIC PERSONALITY DISORDER;** Category 1 credit; Contact: Atlanta Psychoanalytic Society, 3400 Peachtree Rd., N.E., Atlanta 30326.

30-May 1—*Atlanta;* **MEETING, AMBULATORY PEDIATRIC ASSOCIATION;** Contact: R. Weiss, Ambulatory Pediatric Assn., 4525 E. San Francisco, Tuscon, AZ 85712.

MAY

1—*Knoxville, TN;* **PROBLEM CASES IN PATHOLOGY;** Category 1 credit; Contact: Knoxville Academy of Medicine, 422 W. Cumberland Ave., Knoxville, TN 37902.

4-6—*Kiawah Island, SC;* **CURRENT CONCEPTS IN PEDIATRIC ORTHOPAEDIC SURGERY;** Category 1 credit; Contact: American Academy of Orthopaedic Surgeons, Box 6310-A, Chicago, IL 60680.

5-6—*Atlanta;* **THE ADDICTED PATIENT: PRACTICAL APPROACHES TO TREATMENT;** Contact: Institute of Pennsylvania Hospital, 111 N. 49th St., Philadelphia, PA 19139.

8—*Knoxville, TN;* **NEW DEVELOPMENTS IN INTERNAL MEDICINE, UROLOGY, OPHTHALMOLOGY;** Category 1 credit; Contact: Knoxville Academy of Medicine, 422 W. Cumberland Ave., Knoxville, TN 37902.

9-13—*Hilton Head, SC;* **19TH INTERNATIONAL CONFERENCE ON LEGAL MEDICINE;** Contact: B. Hanna, American College of Legal Medicine, 1340 N. Astor St., Ste. 2608, Chicago, IL 60610.

9-13—*Washington, DC;* **75TH CONGRESS ON MEDICAL EDUCATION;** Contact: Gloria Coleman, Association for Hospital Medical Education, 1911 Jefferson Davis Hwy., Ste. 905, Arlington, VA 22202. PH: 703/521-1133.

10-11—*Augusta;* **IMPROVING THE EFFECTIVENESS OF THE MEDICAL OFFICE TEAM;** Contact: Division of Continuing Education, Medical College of Georgia, Augusta 30901. PH: 404/828-3967.

10-12—*Augusta;* **PHYSIOLOGY OF ATRIAL PACEMAKERS;** Category 1 credit; Contact: Division of Continuing Education, Medical College of Georgia, Augusta 30901. PH: 404/828-3967.

17-18—*Pine Mountain;* **7TH ANNUAL CONFERENCE ON PERINATAL MEDICINE: PERINATAL GENETICS;** Contact: Micki L. Souma, M.D., Perinatology, The Medical Center, P.O. Box 951, Columbus 31902.

17-19—*Lake Lanier;* **GENERAL PEDIATRICS;** Category 1 credit; Contact: American Academy of Pediatrics, 1801 Hinman Ave., Evanston, IL 60201.

19-20—*Savannah;* **AMA REGIONAL CME PROGRAM: PULMONARY FUNCTION TESTING AND BLOOD GASES, NEUROLOGY FOR PRIMARY CARE PHYSICIANS, OFFICE DERMATOLOGY, DIABETES, CARDIOVASCULAR DISEASE, HUMAN SEXUALITY, COMMON INFECTIONS, PRACTICE MANAGEMENT:** Category 1 credit; Contact: Dept. of Meeting Services, AMA, 535 N. Dearborn St., Chicago, IL 60610. PH: 312/751-6503.

23-24—*Nashville, TN;* **18TH ANNUAL SEMINAR IN PSYCHIATRY (FOR NON-PSYCHIATRISTS);** Contact: Vanderbilt Continuing Education, 305 Medical Arts Bldg., Nashville, TN 37212. PH: 615/322-2716.

23-25—*Nashville, TN;* **INTERNAL MEDICINE—1979;** Contact: Frank A. Perry Sr., M.D., Director of CME, Meharry Medical College, 1005 18th Ave. North, Nashville, TN 37208. PH: 615/327-6235.

24-26—*Atlanta;* **CLINICAL TOPICS IN GYNECOLOGY AND OBSTETRICS;** Category 1 credit; Contact: Associate Dean for CME, 69 Butler St., S.E., Atlanta 30303. PH: 404/588-3534.

25-27—*Kiawah Island, SC;* **SPRING MEETING, GEORGIA RADIOLOGICAL SOCIETY;** Category 1 credit; Contact: Edgar J. Filson, M.D., 9 Medical Arts Center, Savannah 31405.

26—*Atlanta;* **THE PREVENTION, RECOGNITION, AND IMMEDIATE MANAGEMENT OF ATHLETIC INJURIES;** Category 1 credit; Contact: Associate Dean for CME, 69 Butler St., S.E., Atlanta 30303. PH: 404/588-3534.

26-27—*Atlanta;* **PRIVATE ENTERPRISE PERSPECTIVES ON MEDICINE (PEP SEMINAR);** Category 1 credit; Contact: Sue McAvoy, Medical Association of Georgia, 938 Peachtree St., N.E., Atlanta 30309. PH: 404/876-7535.

JUNE

4-9—*Chattanooga, TN;* **FAMILY PRACTICE REVIEW;** Category 1 credit; Contact: UT College of Medicine, Clinical Education Center, Ste. 400, 921 E. Third St., Chattanooga, TN 37403.

7-8—*Pine Mountain;* **PATIENT EDUCATION CONFERENCE;** Contact: Gerard R. Hummel, Southeastern Institute for Community Health, P.O. Box 1708, LaGrange 30241.

7-9—*Jekyll Island;* **INTERNAL MEDICINE;** Contact: Division of Continuing Education, Medical College of Georgia, Augusta 30901. PH: 404/828-3967.

8-10—*Atlanta;* **EKG INTERPRETATION AND ARRHYTHMIA MANAGEMENT;** Category 1 credit; Contact: International Medical Education Corp., 64 Inverness Dr. East, Englewood, CO 80112. PH: 800/525-8646.

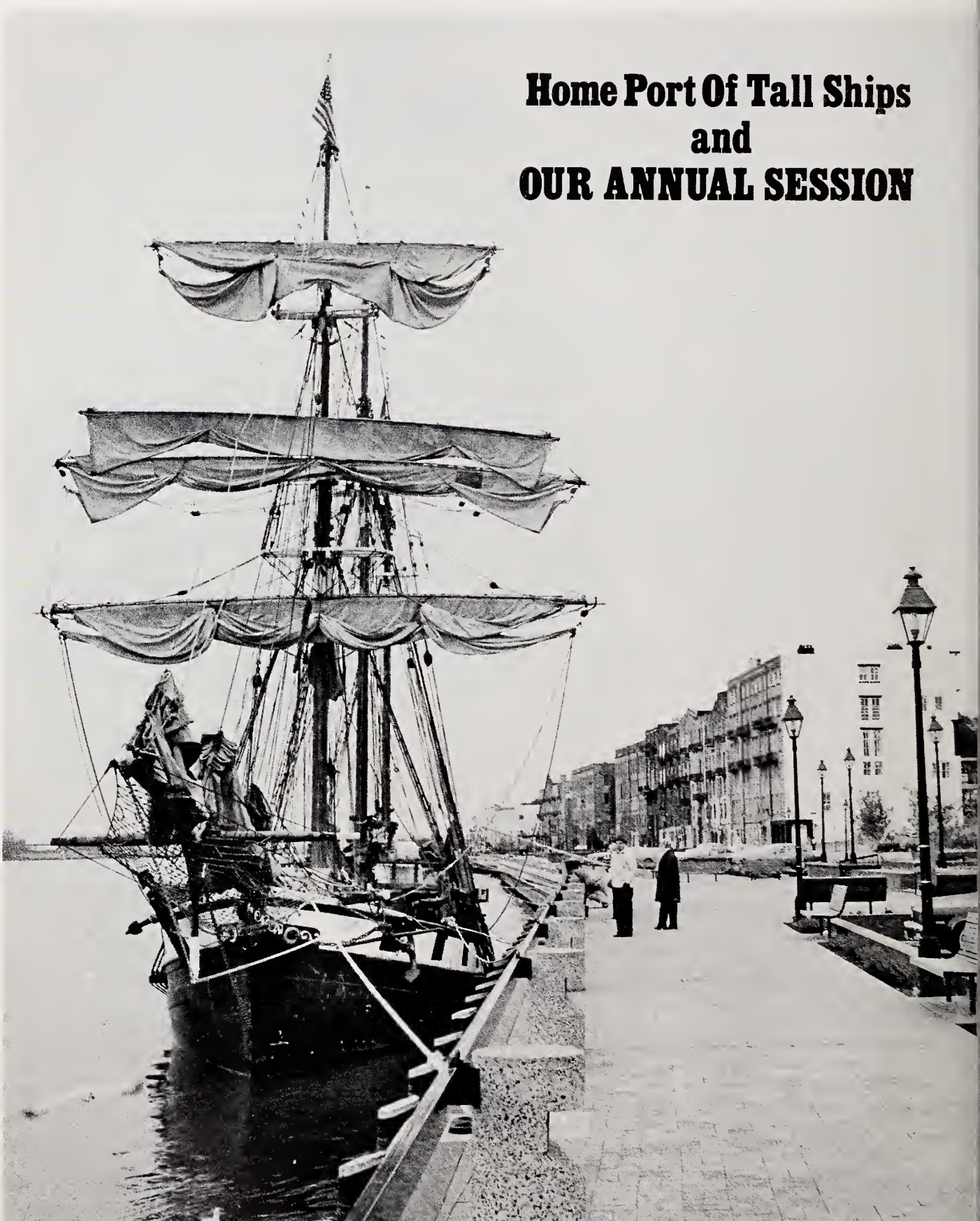
9-10—*Pine Mountain;* **REGIONAL REFRESHER COURSE, AMERICAN SOCIETY OF ANESTHESIOLOGISTS;** Contact: American Society of Anesthesiologists, 515 Busse Hwy., Park Ridge, IL 60068.

17-21—*Sea Island;* **FOURTH ANNUAL SYMPOSIUM ON LUNG DISEASE;** Category 1 credit; Contact: Associate Dean for CME, Emory University School of Medicine, 69 Butler St., S.E., Atlanta 30303. PH: 404/588-3534.

21-23—*Lake Lanier;* **HYPERTENSION 1979: PRACTICAL MANAGEMENT CONSIDERATIONS FOR THE PHYSICIAN IN CLINICAL PRACTICE;** Category 1 credit; Contact: Dale E. Braddy, American College of Chest Physicians, 911 Busse Hwy., Park Ridge, IL 60068. PH: 312/698-2200.

For additional information on these and other meetings, contact MAG, Division of Education 404/876-7535

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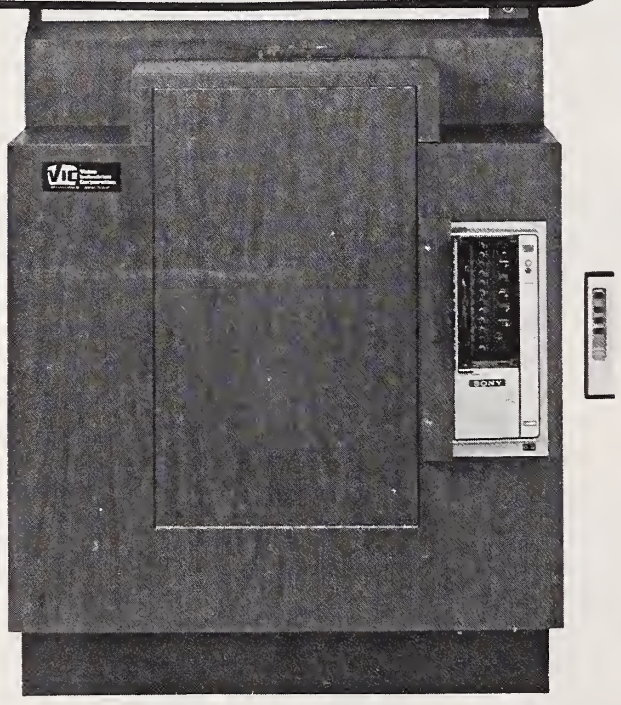
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Indications: Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:
"Possibly" effective: as adjunctive therapy in the treatment of peptic ulcer and in the treatment of the irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis.
Final classification of the less-than-effective indications requires further investigation.

Contraindications: Glaucoma; prostatic hypertrophy, benign bladder neck obstruction; hypersensitivity to chlordiazepoxide HCl and/or clidinium Br.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants, and against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Physical and psychological dependence rarely reported on recommended doses, but use caution in administering Librium® (chlordiazepoxide HCl) to known addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions) reported following discontinuation of the drug.

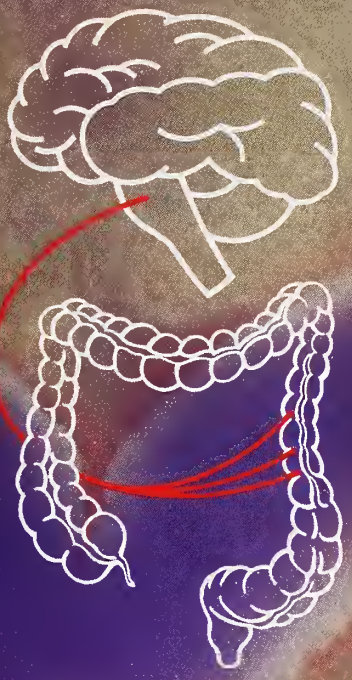
Usage in Pregnancy: **Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy. Advise patients to discuss therapy if they intend to or do become pregnant.**

As with all anticholinergics, inhibition of lactation may occur.

Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude ataxia, oversedation, confusion (no more than 2 capsules/day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacology of agents, particularly potentiating drugs such as MAO inhibitors, phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions reported in psychiatric patients. Employ usual precautions in treating anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation reported very rarely in patients receiving the drug and oral anticoagulants, causal relationship not established.

Adverse Reactions: No side effects or manifestations not seen with either compound alone reported with Librax. When chlordiazepoxide HCl is used alone, drowsiness, ataxia, confusion may occur, especially in elderly and debilitated; avoidable in most cases by proper dosage adjustment, but also occasionally observed at lower dosage ranges. Syncope reported in a few instances. Also encountered: isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent, generally controlled with dosage reduction; changes in EEG patterns may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice, hepatic dysfunction reported occasionally with chlordiazepoxide HCl, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax typical of anticholinergic agents, *i.e.*, dryness of mouth, blurring of vision, urinary hesitancy, constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.

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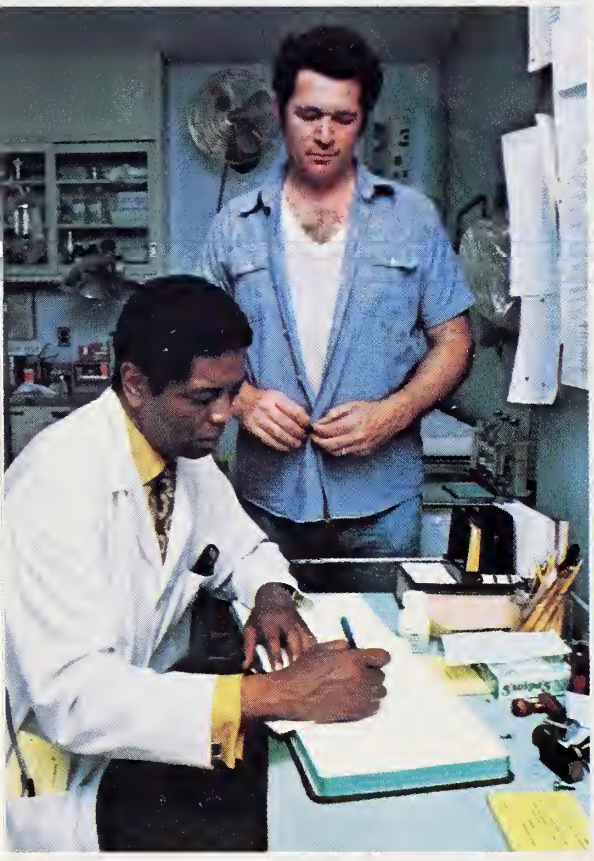
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*Librax has been evaluated as possibly effective for this indication.
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The evidence of experience

Since October 1974 when Motrin® (ibuprofen) was introduced in the United States, it has been used by more than 6,000,000 patients with rheumatoid arthritis* or osteoarthritis. Rarely has an ethical pharmaceutical product been prescribed for so many patients in so short a time. In addition, more than 450 studies presenting new data related to Motrin have been published.

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*The safety and effectiveness of Motrin have not been established in patients with Functional Class IV rheumatoid arthritis (incapacitated, largely or wholly bedridden, or confined to wheelchair; little or no self-care).

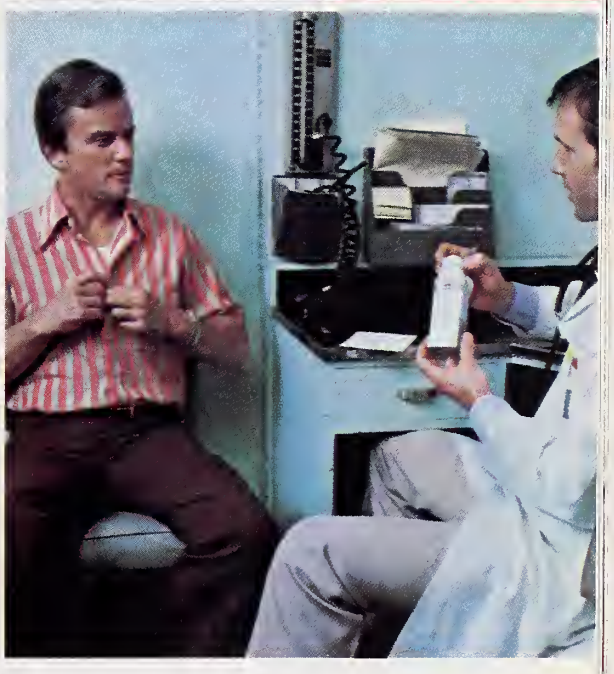
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Motrin 400 mg TABLETS
ibuprofen, Upjohn

The confidence that comes from experience—one more reason to prescribe Motrin.

Please turn page for a brief summary of prescribing information.

Upjohn The Upjohn Company, Kalamazoo, Michigan 49001

I-6857-4

The confidence that comes from experience—
one more reason to prescribe

Motrin 400 mg TABLETS
ibuprofen, Upjohn

Indications and Usage: Treatment of signs and symptoms of rheumatoid arthritis and osteoarthritis during acute flares and in long-term management. Safety and efficacy have not been established in Functional Class IV rheumatoid arthritis.

Contraindications: Individuals hypersensitive to it, or with the syndrome of nasal polyps, angioedema and bronchospastic reactivity to aspirin or other nonsteroidal anti-inflammatory agents (see WARNINGS).

Warnings: Anaphylactoid reactions have occurred in patients with aspirin hypersensitivity (see CONTRAINDICATIONS).

Peptic ulceration and gastrointestinal bleeding, sometimes severe, have been reported. Ulceration, perforation, and bleeding may end fatally. An association has not been established. Motrin should be given under close supervision to patients with a history of upper gastrointestinal tract disease, only after consulting ADVERSE REACTIONS.

In patients with active peptic ulcer and active rheumatoid arthritis, nonulcerogenic drugs, such as gold, should be tried. If Motrin must be given, the patient should be under close supervision for signs of ulcer perforation or gastrointestinal bleeding.

Precautions: Blurred and/or diminished vision, scotomata, and/or changes in color vision have been reported. If these develop, discontinue Motrin and the patient should have an ophthalmologic examination, including central visual fields.

Fluid retention and edema have been associated with Motrin; use with caution in patients with a history of cardiac decompensation.

Motrin can inhibit platelet aggregation and prolong bleeding time. Use with caution in persons with intrinsic coagulation defects and those on anticoagulant therapy.

Patients should report signs or symptoms of gastrointestinal ulceration or bleeding, blurred vision or other eye symptoms, skin rash, weight gain, or edema.

To avoid exacerbation of disease or adrenal insufficiency, patients on prolonged corticosteroid therapy should have therapy tapered slowly when Motrin is added.

Drug interactions. *Aspirin* used concomitantly may decrease Motrin blood levels. *Coumarin:* Bleeding has been reported in patients taking Motrin and coumarin.

Pregnancy and nursing mothers: Motrin should not be taken during pregnancy or by nursing mothers.

Adverse Reactions

Incidence greater than 1%

Gastrointestinal: The most frequent type of adverse reaction occurring with Motrin (ibuprofen) is gastrointestinal (4% to 16%). This includes nausea*, epigastric pain*, heartburn*, diarrhea, abdominal distress, nausea and vomiting, indigestion, constipation, abdominal cramps or pain, fullness of the GI tract (bloating and flatulence). **Central Nervous System:** Dizziness*, headache, nervousness. **Dermatologic:** Rash* (including maculopapular type), pruritus. **Special Senses:** Tinnitus. **Metabolic:** Decreased appetite, edema, fluid retention. Fluid retention generally responds promptly to drug discontinuation (see PRECAUTIONS).

Incidence: Unmarked 1% to 3%; *3% to 9%.

Incidence less than 1 in 100

Gastrointestinal: Upper GI ulcer with bleeding and/or perforation, hemorrhage, melena. **Central Nervous System:** Depression, insomnia. **Dermatologic:** Vesiculobullous eruptions, urticaria, erythema multiforme. **Cardiovascular:** Congestive heart failure in patients with marginal cardiac function, elevated blood pressure. **Special Senses:** Amblyopia (see PRECAUTIONS). **Hematologic:** Leukopenia, decreased hemoglobin and hematocrit.

Causal relationship unknown

Gastrointestinal: Hepatitis, jaundice, abnormal liver function. **Central Nervous System:** Paresthesias, hallucinations, dream abnormalities. **Dermatologic:** Alopecia, Stevens-Johnson syndrome. **Special Senses:** Conjunctivitis, diplopia, optic neuritis. **Hematologic:** Hemolytic anemia, thrombocytopenia, granulocytopenia, bleeding episodes. **Allergic:** Fever, serum sickness, lupus erythematosus syndrome. **Endocrine:** Gynecomastia, hypoglycemia. **Cardiovascular:** Arrhythmias. **Renal:** Decreased creatinine clearance, polyuria, azotemia.

Overdosage: In cases of acute overdosage, the stomach should be emptied. The drug is acidic and excreted in the urine, so alkaline diuresis may be beneficial.

Dosage and Administration: Suggested dosage is 300 or 400 mg t.i.d. or q.i.d. Do not exceed 2400 mg per day.

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Bottles of 500	NDC 0009-0750-02
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The Epidemiologic Picture of Legionnaires' Disease

STEPHEN B. THACKER, M.D., and
MICHAEL B. GREGG, M.D., *Atlanta**

Introduction

THIRTY YEARS after John Snow's classic study in 1854 in which he related impure water supply to cholera, Robert Koch isolated the *Vibrio cholerae* bacillus. In recent years, new scourges such as the Ebola and Marburg fever viruses have been definitively identified in the laboratory, but the environment reservoirs of these organisms remain elusive.[1, 2] The most dramatic recent medical event in the United States was an outbreak of respiratory illness among delegates to an American Legion convention in the summer of 1976 which left the medical world groping for answers. Within a few months, a previously unknown bacterium was isolated in the laboratory (Figure 1).[3, 4] To date, however, results of detailed epidemiologic investigations have only partially revealed the environmental source(s) and mode(s) of transmission of the Legionnaires' disease bacterium (LDB).[5-11]

Nevertheless, since the LDB was isolated and characterized in 1977, we have had the extraordinary opportunity to analyze data and biologic specimens from earlier epidemics of unknown cause and from epidemics of Legionnaires' disease (LD) that occurred in 1977 and 1978. In this article, we will summarize the epidemiologic and environmental aspects of 16 epidemics of LD recognized since 1965.

The Epidemics

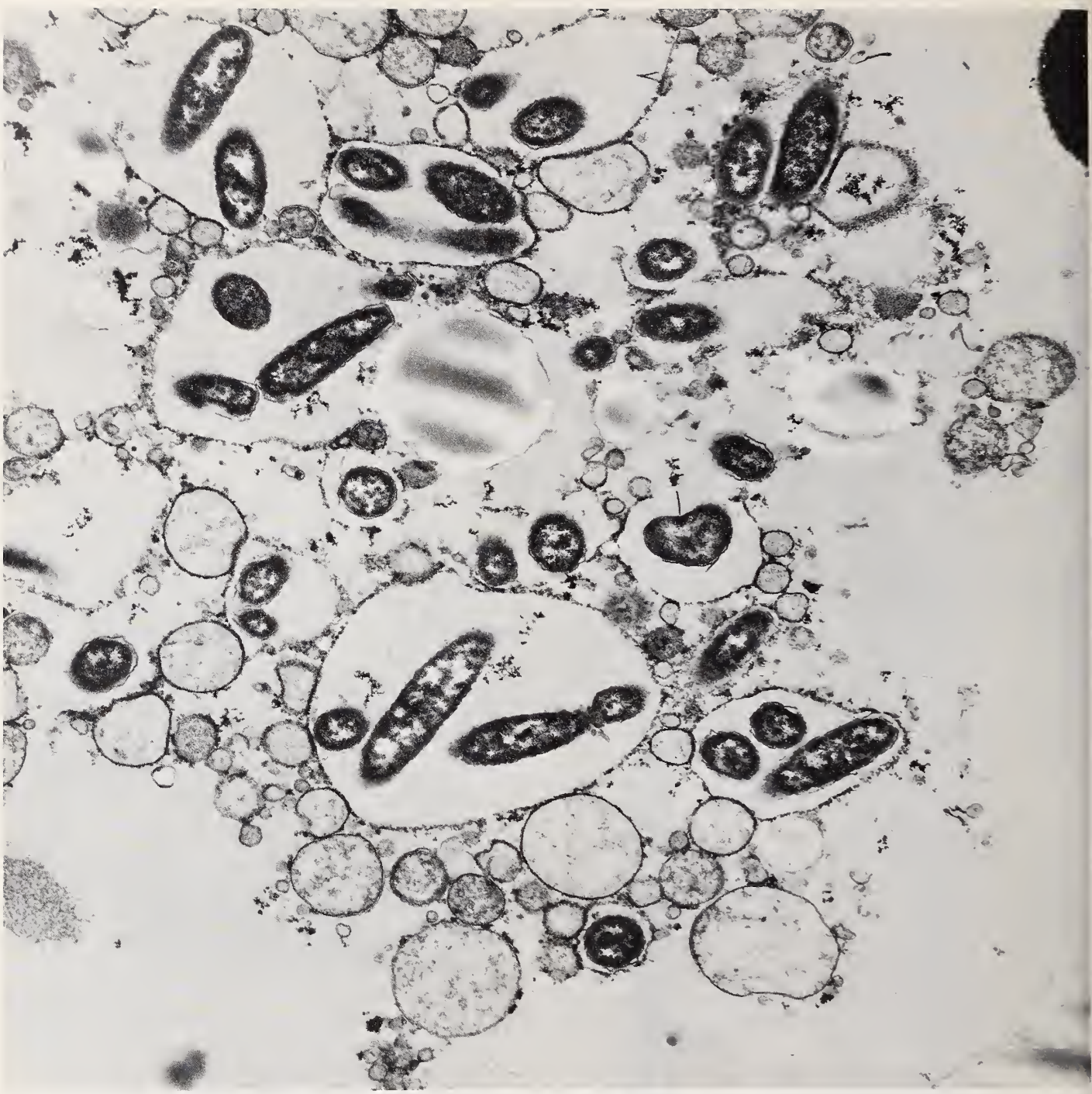
On July 27, 1965, a 76-year-old patient at Saint Elizabeth's Psychiatric Hospital in Washington, D.C., had onset of a febrile illness and pneumonia. In the next several weeks, 81 residents of the hospital experienced a similar illness characterized either by a temperature of at least 102°F. and a cough or by x-ray evidence of pneumonia. The illness was characterized by an abrupt onset of high fever, cough, malaise, and pneumonia; 14 cases were fatal. Although no etiologic agent was found, the association of disease with sleeping near open windows, access to the grounds, and proximity to excavation sites suggested airborne transmission — possibly of infectious organisms from the soil.[5]

On July 2, 1968, employees of the Oakland County Health Department in Pontiac, Michigan, experienced a respiratory illness characterized by abrupt onset of high fever, chills, headaches, cough, and myalgias. The only factor that the 95 employees and 49 patients and visitors who became ill over a 4-week period shared was exposure to the two-story health department building. There were no deaths and no confirmed cases of pneumonia. A defective air-conditioning system was implicated as the source of airborne transmission of an unknown etiologic agent. Years later, the LDB was found in specimens from guinea pigs exposed to the building and from those exposed to water from the evaporative condenser of the Pontiac Health Department facility in 1968.[6]

In July and August of 1976, a respiratory illness affected at least 182 persons associated with an American Legion Convention at the Bellevue-Stratford Hotel in Philadelphia. This illness was also characterized by fever, cough, chills, and malaise; it resulted in 29 deaths. Again, no etiologic agent was identified, and although the mode of transmission was thought to be airborne, it was not confirmed.[3]

The epidemiologic investigation following the Philadelphia outbreak led to the association (and subsequent laboratory confirmation) of LD with an

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Courtesy of Dr. Francis W. Chandler, Jr., Pathology Division, Center for Disease Control, Atlanta, Ga.

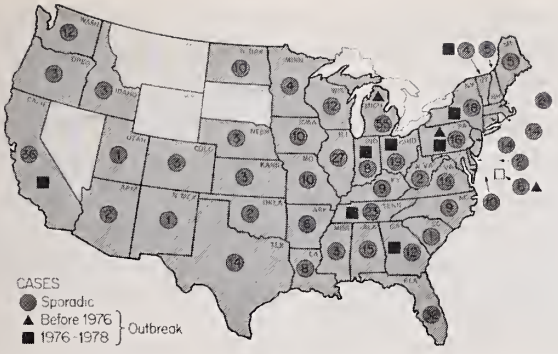
Figure 1 — Electron micrograph of Legionnaires' Disease bacteria *(Legionella pneumophila)* grown in egg yolk membrane (uranyl acetate and lead citrate, × 21,130).

earlier outbreak of respiratory illness in Philadelphia.[12] After the LDB was isolated and characterized, more precise investigations of other outbreaks in Ohio, Vermont, Tennessee, California, Indiana, New York, Benidorm (Spain), and Nottingham (England) and of isolated cases throughout the world could be conducted.[7-10, 13-16] The combined data obtained from the aforementioned investigations represent the results of an unprecedented focus on a new disease entity.

A recent outbreak of LD affected eight golfers at a country club in Atlanta, Georgia, and caused 1 death. LDBs were isolated from a water sample obtained from an evaporative condenser facing the 10th tee of the golf course.[17]

Epidemiologic Findings

Although LD apparently occurs throughout the year, the incidence of both outbreaks and isolated cases probably peaks in summer and early fall. Outbreaks and isolated cases have also been temporally associated with excavation.[5-6, 11] Heavy rainfall and winds preceded the outbreaks in Washington, D.C., and Pontiac, Michigan, but any cause-effect relationship between LD and meteorologic phenomena remains speculative. Results of a case-control study



Courtesy of the Center for Disease Control, Atlanta, Ga.

Figure 2 — Sporadic cases of Legionnaires' Disease, by state, United States 1976-October 1978.



Courtesy of the Center for Disease Control, Atlanta, Ga.

Figure 3 — ■ Countries reporting confirmed indigenous or imported cases of Legionnaires' Disease.

of isolated cases of LD also indicated an association with travel.

The LDB has been confirmed to be the cause of disease in 43 states (Figure 2) and several foreign countries, which suggests that it is distributed worldwide (Figure 3). Outbreaks of disease have been associated with hotels, hospitals, a health department, and a country club. Data suggest that for some people, LD has been a nosocomial infection, but efforts to distinguish actual disease transmission from recrudesence of earlier illness have been unsuccessful.[7, 9, 15] Finally, the investigation of LD in Vermont indicated that the infection may have endemic foci.[7]

The pneumonia associated with LD is similar to other bacterial pneumonias in that it tends to affect the elderly more readily and with increased severity; fewer than 10 children less than 10 years old have had confirmed LD. Persons with underlying disease and those who smoke are also more likely to contract LD. Case-control study results show that construction workers are more likely than controls to experience LD.[11] The disease develops more often in men than in women. Although results of the case-control study indicate that blacks are more likely than whites to acquire LD, this relationship has not been seen in results of outbreak investigations.[5, 11]

Environmental Studies

LDB has been isolated several times in specimens from air-conditioner cooling towers or evaporative condensers and from fresh water sources.[10, 17] There was a temporal association between the interval of cooling-tower or evaporative-condenser exposure and the occurrence of cases of LD in three outbreaks, but no direct cause-and-effect relationship has been proven. The LDB has survived in tap water stored at room temperature for over 2 years.

Data compiled from these outbreaks clearly indicate an airborne mode of spread, either in association with cooling towers or evaporative condensers in air-conditioning systems or by other airborne routes. The minimal duration of exposure which causes infection and the precise mechanism of exposure are unclear, but persons exposed for as little as 20 minutes to the health department building in Pontiac, Michigan, developed LD. The complex interplay of human susceptibility and the virulence and infectivity of the LDB have yet to be described.

Discussion

Before the LDB was isolated, no new family of bacteria pathogenic in humans had been identified for 20 years, and none with the dramatic impact of the LDB had been isolated since the pertussis bacillus 60 years ago. The LDB is not really "new"; however, it has been isolated from blood specimens frozen since 1947. Results of serologic tests confirm that an outbreak affecting 81 persons in 1965 was caused by the LDB, and guinea pig specimens from the 1968 outbreak contained LDB 9 years later. There is no reason to believe that the organism was not present many years before.

The proposed scientific name of the LDB is *Legionella pneumophila* (proposed family Legionellaceae, *Legionella,* genus novum, *pneumophila,* species nova).[18] Researchers are searching for simpler, more refined selective media. Direct fluorescent antibody testing of pathologic tissue, lung biopsy material, or sputum allows clinicians to diagnose LD rapidly.[19] Although efforts continue to improve the precision of the currently used indirect fluorescent antibody test, hemagglutination testing is also being evaluated. Other researchers are trying to isolate any toxins produced by the LDB. Finally, standard sterilization procedures can be used to kill the LDB.

In conjunction with state and local health departments and the private medical community, epidemiologists at the Center for Disease Control (CDC) have examined the complex relationships among host, agent, and environment. Outbreak investigations continue to provide enormous amounts of new information on LD. Results of a large case-

control study of 100 isolated cases of LD have been analyzed. A study in which buildings associated with LD outbreaks are compared with similar institutions with no known association with the disease is underway.

The true ecologic niche of the LDB continues to elude investigators. Although the organism has been isolated from several places in nature, the mode of transmission of LD has not been clearly demonstrated. Nevertheless, the possible role of man-made air-handling systems has been clearly brought into focus, and the possibility of setting hygienic standards for such systems has been proposed. Environmental sampling in areas epidemiologically related to sporadic cases or to outbreaks provided the isolates mentioned above. The continued systematic search for the organism and the development of improved selective media should soon lead to the clear understanding of the environmental source and mode of spread of the LDB.

Today a diagnosis of LD can be confirmed with laboratory data, but too often the confirmation is provided too late to benefit the patient. The physician whose patient has moderate-to-severe culture-negative pneumonia with patchy infiltrates, high fever, cough, headache, and gastrointestinal symptoms should suspect LD. If the patient is a male over 50 with underlying chronic disease or is a smoker who becomes ill in summer or early fall, LD should be strongly suspected.

When the clinical picture suggests LD, the physician should do several things. Acute and convalescent-phase blood specimens should be drawn 3 to 4 weeks apart and the sera forwarded to the state health department for analysis. The state health department can also provide guidance for handling sputum or pleural fluid specimens to be used for cultures or direct fluorescent antibody testing. The currently recommended, commercially available media for isolating the LDB are a Mueller-Hinton agar supplemented with 2 percent IsoVitaleX and 1 percent hemoglobin and a chocolate agar supplemented with 2 percent IsoVitaleX. Therapy should include good supportive nursing care. Erythromycin, either orally or parenterally, is the initial drug of choice. Rifampin should only be prescribed for patients with confirmed LD who have responded poorly to other therapy and should only be given in combination with erythromycin. Finally, all cases should be reported to the local and/or state health department for epidemiologic investigation and follow-up.

The enormous effort of investigating the mysterious disease that affected persons from the American Legion Convention in Philadelphia in the summer of 1976 has been supplemented by the work of researchers throughout the world. The culmination of these efforts in the International Symposium on Legionnaires' Disease in November, 1978, represented an enormous advancement in medical science. In just over 2 years a new bacterium was isolated, its basic nature was described, successful therapeutic recommendations were made, and some of its natural habitats were identified. While much remains to be done, this 2-year venture involving a previously unknown organism is remarkable both in its scope and its results.

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This rare case of hemoptysis in the young is reported in a 22-year-old patient.

Plasma Cell Granuloma (Histiocytoma) of the Lung

THOMAS F. KELLY, M.D., CHARLES W. SEWELL, M.D., and KAMAL A. MANSOUR, M.D., *Atlanta**

HISTIOCYTOMA OR PLASMA CELL granuloma of the lung is a rare, benign tumor occurring mostly in younger patients. It is typically composed of plasma cells, lymphocytes, histiocytes, various amounts of fibrous tissue, and a variable vascular component. Because of the emphasis of the particular cell type found in abundance, these tumors have been variously referred to as plasma cell tumors or plasmacytomas,[3, 8] histiocytomas,[20, 22] plasma cell granulomas,[10] xanthomas,[17] xanthomatotic pseudo-tumors,[22] post-inflammatory tumors,[21] sclerosing hemangiomas,[6, 13, 16] and vascular endotheliomas.[4]

Case Report

On June 6, 1977, a 22-year-old black male was admitted to Emory University Hospital in Atlanta because of hemoptysis. He had been feeling well until approximately 16 hours prior to his admission, when he coughed up about 2-3 tablespoons of bright red blood both by mouth and by tracheostomy. There was no recurrence of this between the initial onset and the time of admission. The patient denied any other symptoms including recent history of illness, tuberculosis exposure, chest pain, shortness of breath, dyspnea on exertion, and productive cough. He stated that he played basketball every day.

In 1971, the patient had suffered laryngeal trauma which required a tracheostomy. Subsequent removal of the tracheostomy tube required replacement because of laryngeal stenosis and paralysis of the right vocal cord. He underwent a subsequent exploration of the area revealing a recurrent nerve injury and a fixed arytenoid cartilage. Subglottic stenosis required a permanent tracheostomy.

On examination, there was no lymph node enlargement or any evidence of any acute disease process.

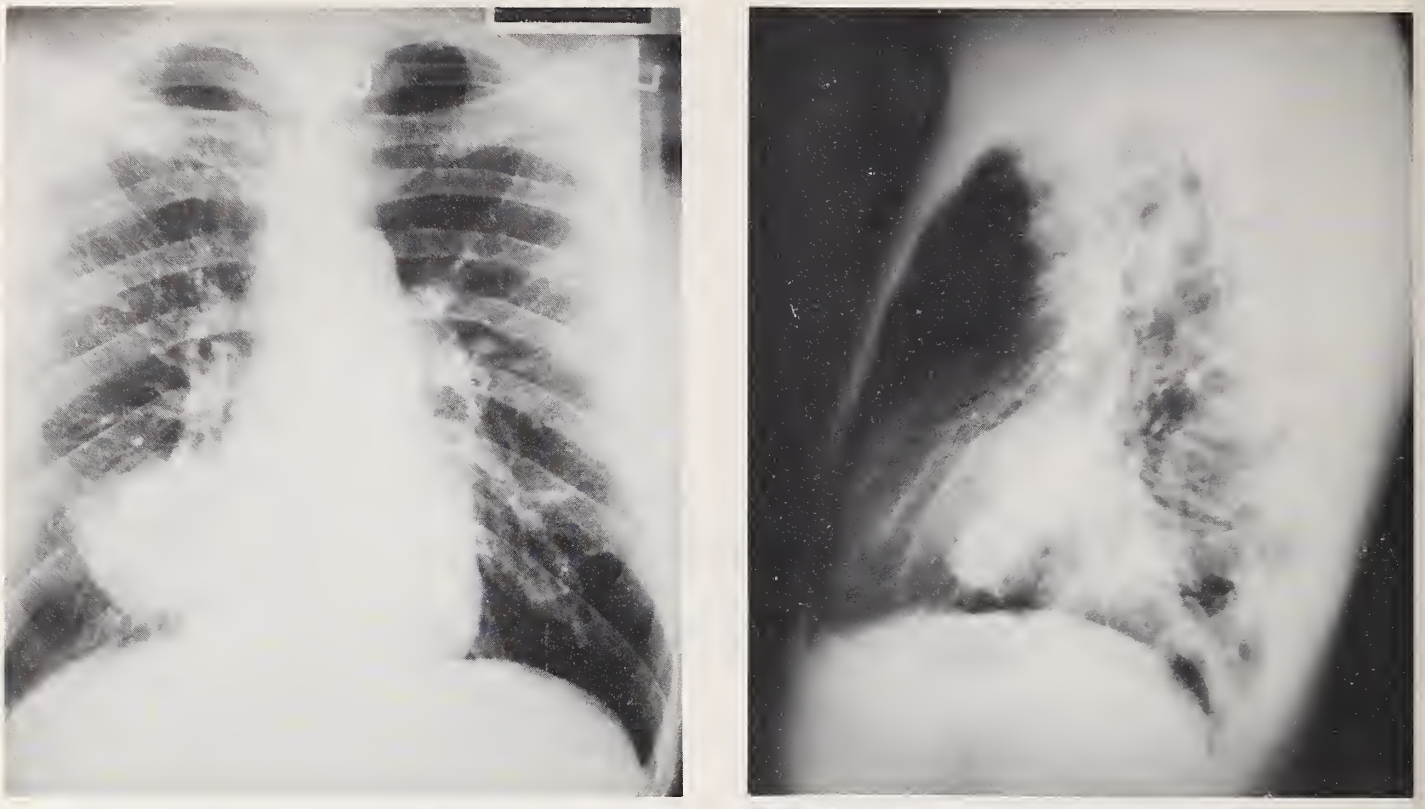
Laboratory examination revealed a hemoglobin of 10.8, hematocrit of 33%. Urinalysis was negative, and the SMA-12 was within normal limits. Routine cultures and acid fast and fungus stains of the sputum were negative.

Chest x-ray on admission revealed three large masses in the right lower lobe (Figures 1-2). The largest was 7 cm. in diameter, another was 5 cm., and another was 3 cm. Tomograms revealed three masses as before without calcification or cavitation. An intravenous pyelogram (IVP) revealed a left upper pole kidney abnormality demonstrated by splaying of the mid and upper calyceal system. Repeat IVP with tomography revealed splaying without evidence of mass formation. Barium enema was negative.

The patient underwent surgery on June 23. A very large, rock-hard mass was found encompassing most of the right middle and right lower lobes, with adherence to the phrenic nerve and pericardium. The right lower lobe and the right middle lobe were removed.

* Dr. Kelly is Senior Resident, Thoracic and Cardiovascular Surgery, Dr. Sewell is Assistant Professor of Pathology and Laboratory Medicine, Dr. Mansour is Associate Professor of Surgery, Thoracic and Cardiovascular at Emory University School of Medicine, Atlanta, GA.

Direct reprint requests to Dr. Mansour. His address is Thoracic Surgery, Emory University Clinic, 1365 Clifton Rd., NE, Atlanta, GA 30322.



Figures 1-2 — Posterior anterior (L) and lateral (R) chest radiographs, showing a rather sharply defined, large trilobulated mass in the right lower lobe adjacent to the heart.

There were several large peribronchial and periesophageal nodes which were sent for frozen section and returned with an indeterminate diagnosis. The gross description on the final pathology report was a yellowish tumor involving both the right lower and right middle lobes (Figure 3). It was firm, noncavitary, and measured 12x8x7 cm. It did not involve the pleural surface. The diagnosis was pulmonary histiocytoma (post inflammatory tumor, plasma cell granuloma) (Figures 4-5). Examination of the lymph nodes revealed nonspecific lymphadenitis of peribronchial lymph nodes.

The patient's postoperative course was uneventful, and he was discharged on the ninth postoperative day in excellent condition. He was last seen 9 months after surgery, and he has remained asymptomatic.

Discussion

In 1973, Liebow and Bahadori[2] reported their experience with 40 cases of plasma cell granuloma of the lung. The authors found that these tumors were the most commonly isolated primary tumors in children under 16 years of age. Twenty-five of the 40 patients were females, ranging in age from 13 months to 68 years. In 24 patients, the lesion was discovered during a routine examination, with no previous history of a related illness. A nonproductive cough was observed in seven patients. Six patients recorded pains variously in the chest, back, shoulder, and arm, lasting from 2 weeks to several months. There were no other specific physical findings in these patients.

Laboratory findings were also nonspecific, with normal white blood cell counts and an absence of a typical myeloma electrophoretic pattern. Lupus erythematosus preparations and all skin tests were negative. Radiographic findings in 23 patients presented as solitary, circumscribed tumor-like masses of round or oval shape. In 10 of these 23 patients, the descriptive term "coin lesion" was applied. In nine patients, the shadows were ill-defined and, in four, they indicated atelectasis or pneumonia. Pathologic findings in most instances were peripheral, with parenchymal masses up to 12 cm. in diameter that involved either lung with almost equal frequency. On gross examination the tumor was usually firm and characteristically yellow-white in color. Histologically, mature plasma cells were the major and constant component of the cellular population, being strikingly predominant in 25 of the 40 cases. Most were mature and occasionally multinucleated, and scattered Russell bodies were often present. Since this study, eight additional cases have been reported in the literature.[7, 9, 11, 14, 15, 23]

Treatment of these tumors consists of extirpation. In the study discussed above, there was only one recurrence. Lobectomy or segmental resection appear to be sufficient therapy. The lesions are unresponsive to antibiotics and/or steroids and in the patients who received chemotherapy for tuberculosis, there was no response.



Figure 3 — Transection through the tumor reveals a firm yellowish-white mass with expansile borders. Note sparing of bronchus and pleural surface.

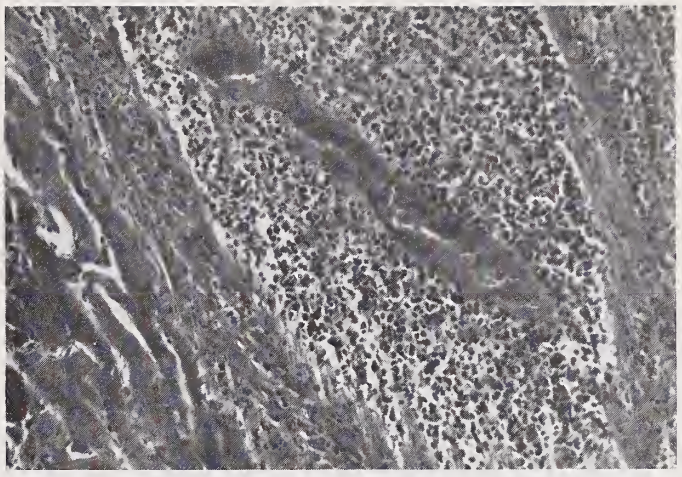


Figure 4 — Photomicrograph showing vascular channel surrounded by cuff of mature plasma cells. Dense collagenous tissue is present at the periphery.

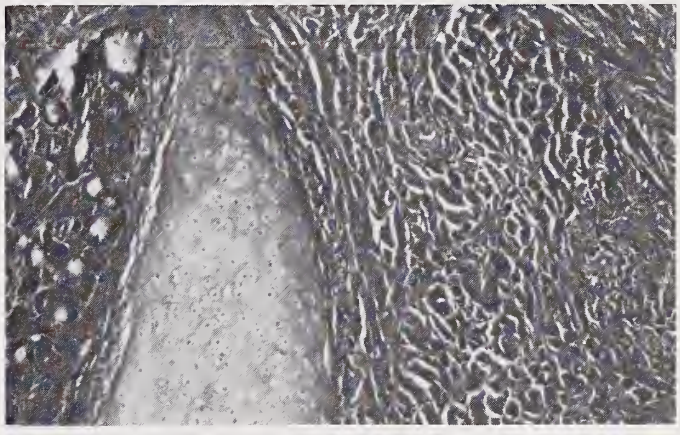


Figure 5 — Typical hyalinized collagenous fibrous tissue extends just beneath the bronchial cartilage. The bronchial mucous membrane is unremarkable.

The etiology of histiocytoma is unknown. Arean and Wheat[1] consider it to be a true tumor, but Sherwin, Kern, and Jones[18] consider it to be of post-inflammatory origin. Similar tumors have occurred in persons after accidental contamination with the Yaba virus,[5] and experimentally, it is possible to produce benign histiocytomas in monkeys with Yaba viruses.[19] Although the cells of these growths are typical of chronic inflammation, the tumor-like structure and the intensity of the cell reaction is atypical. It is, therefore, uncertain whether these tumors should be considered inflammatory or neoplastic in the lungs as well as in other organs. The possibility of an immunologically determined pathogenesis must be considered in any lesion containing large numbers of plasma cells.[12] The lungs are directly exposed to the external environment and thus to the inhalation of antigenic substances. For the production of a single large hypersensitivity reaction, however, it would seem that a discrete mass of antigen must somehow reach one part of the lung without involving others. Such a possibility should be further investigated.

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Brief Summary
INDICATION: Tenuate and Tenuate Dospan are indicated in the management of exogenous obesity as a short-term adjunct (a few weeks) in a regimen of weight reduction based on caloric restriction. The limited usefulness of agents of this class should be measured against possible risk factors inherent in their use such as those described below.
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WARNINGS: If tolerance develops, the recommended dose should not be exceeded in an attempt to increase the effect; rather, the drug should be discontinued. Tenuate may impair the ability of the patient to engage in potentially hazardous activities such as operating machinery or driving a motor vehicle; the patient should therefore be cautioned accordingly. *Drug Dependence:* Tenuate has some chemical and pharmacologic similarities to the amphetamines and other related stimulant drugs that have been extensively abused. There have been reports of subjects becoming psychologically dependent on diethylpropion. The possibility of abuse should be kept in mind when evaluating the desirability of including a drug as part of a weight reduction program. Abuse of amphetamines and related drugs may be associated with varying degrees of psychologic dependence and social dysfunction which, in the case of certain drugs, may be severe. There are reports of patients who have increased the dosage to many times that recommended. Abrupt cessation following prolonged high dosage administration results in extreme fatigue and mental depression; changes are also noted on the sleep EEG. Manifestations of chronic intoxication with anorectic drugs include severe dermatoses, marked insomnia, irritability, hyperactivity, and personality changes. The most severe manifestation of chronic intoxications is psychosis, often clinically indistinguishable from schizophrenia. *Use in Pregnancy*: Although rat and human reproductive studies have not indicated adverse effects, the use of Tenuate by women who are pregnant or may become pregnant requires that the potential benefits be weighed against the potential risks. *Use in Children*: Tenuate is not recommended for use in children under 12 years of age.
PRECAUTIONS: Caution is to be exercised in prescribing Tenuate for patients with hypertension or with symptomatic cardiovascular disease, including arrhythmias. Tenuate should not be administered to patients with severe hypertension. Insulin requirements in diabetes mellitus may be altered in association with the use of Tenuate and the concomitant dietary regimen. Tenuate may decrease the hypotensive effect of guanethidine. The least amount feasible should be prescribed or dispensed at one time in order to minimize the possibility of overdosage. Reports suggest that Tenuate may increase convulsions in some epileptics. Therefore, epileptics receiving Tenuate should be carefully monitored. Titration of dose or discontinuance of Tenuate may be necessary.
ADVERSE REACTIONS: *Cardiovascular*: Palpitation, tachycardia, elevation of blood pressure, precordial pain, arrhythmia. One published report described T-wave changes in the ECG of a healthy young male after ingestion of diethylpropion hydrochloride. *Central Nervous System*: Overstimulation, nervousness, restlessness, dizziness, jitteriness, insomnia, anxiety, euphoria, depression, dysphoria, tremor, dyskinesia, mydriasis, drowsiness, malaise, headache; rarely psychotic episodes at recommended doses. In a few epileptics an increase in convulsive episodes has been reported. *Gastrointestinal*: Dryness of the mouth, unpleasant taste, nausea, vomiting, abdominal discomfort, diarrhea, constipation, other gastrointestinal disturbances. *Allergic*: Urticaria, rash, ecchymosis, erythema. *Endocrine*: Impotence, changes in libido, gynecomastia, menstrual upset. *Hematopoietic System*: Bone marrow depression, agranulocytosis, leukopenia. *Miscellaneous*: A variety of miscellaneous adverse reactions has been reported by physicians. These include complaints such as dyspnea, hair loss, muscle pain, dysuria, increased sweating, and polyuria.
DOSAGE AND ADMINISTRATION: Tenuate (diethylpropion hydrochloride): One 25 mg. tablet three times daily, one hour before meals, and in midevening if desired to overcome night hunger. Tenuate Dospan (diethylpropion hydrochloride) controlled-release: One 75 mg. tablet daily, swallowed whole, in midmorning. Tenuate is not recommended for use in children under 12 years of age.
OVERDOSAGE: Manifestations of acute overdosage include restlessness, tremor, hyperreflexia, rapid respiration, confusion, assaultiveness, hallucinations, panic states. Fatigue and depression usually follow the central stimulation. Cardiovascular effects include arrhythmias, hypertension or hypotension and circulatory collapse. Gastrointestinal symptoms include nausea, vomiting, diarrhea, and abdominal cramps. Overdose of pharmacologically similar compounds has resulted in fatal poisoning, usually terminating in convulsions and coma. Management of acute Tenuate intoxication is largely symptomatic and includes lavage and sedation with a barbiturate. Experience with hemodialysis or peritoneal dialysis is inadequate to permit recommendation in this regard. Intravenous phentolamine (Regitine®) has been suggested on pharmacologic grounds for possible acute, severe hypertension, if this complicates Tenuate overdosage.

Product Information as of April, 1976

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References: 1. Citations available on request—Medical Research Department, MERRELL RESEARCH CENTER, MERRELL-NATIONAL LABORATORIES, Cincinnati, Ohio 45215. 2. Hoekenga, M.T., O'Dillon, R.H., and Leyland, H.M.: A Comprehensive Review of Diethylpropion Hydrochloride. International Symposium on Central Mechanisms of Anorectic Drugs, Florence, Italy, Jan. 20-21, 1977.

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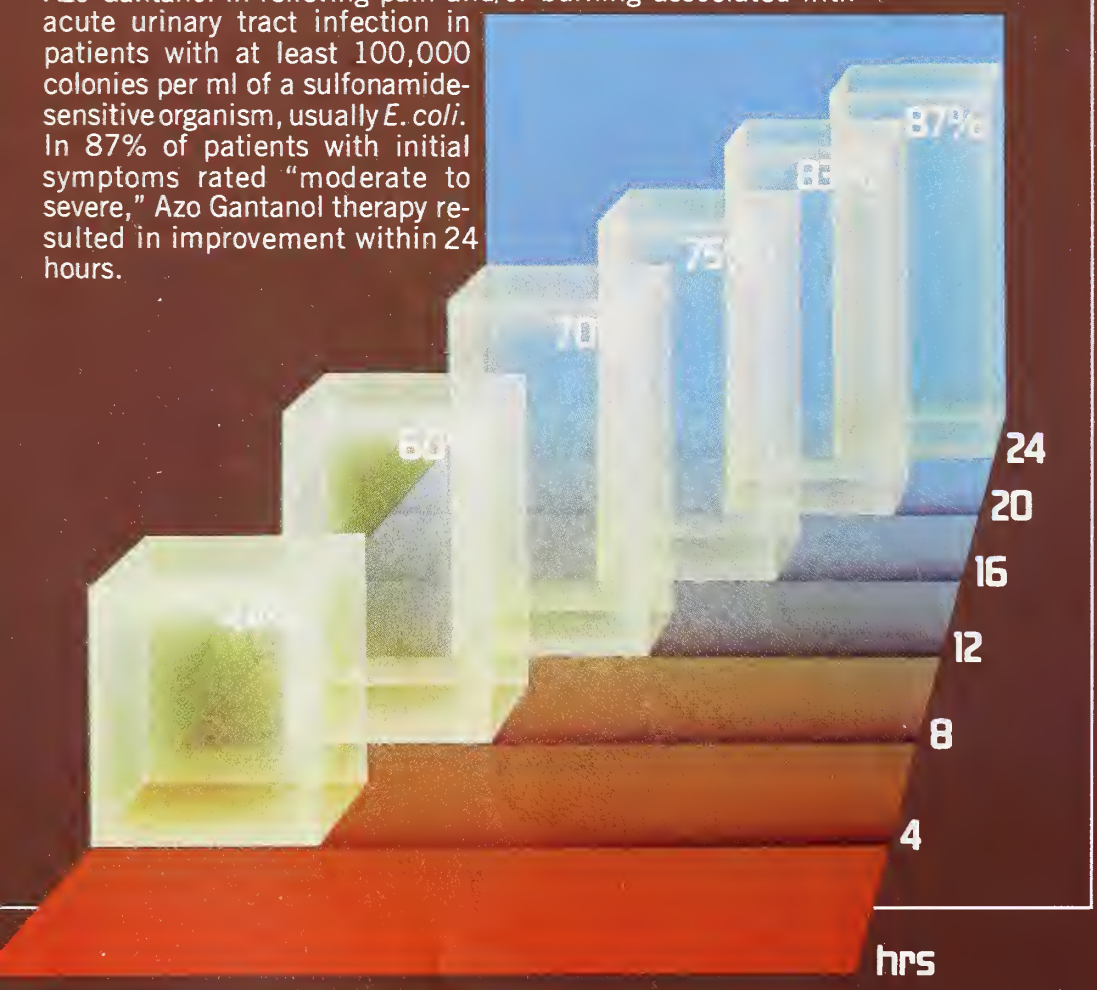
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Before prescribing, please consult complete pro uct information, a summary of which follows:

Indications: In adults, urinary tract infections complicated by pain (primarily pyelonephritis, pyelitis and cystitis) due to susceptible organism (usually *E. coli, Klebsiella-Aerobacter, Staphylococcus aureus, Proteus mirabilis,* and, less frequently, *Proteus vulgaris*) in the absence of obstructive uropathy or foreign bodies. **Note: Ca fully coordinate *in vitro* sulfonamide sensitivity tests with bacteriologic and clinical response; ad aminobenzoic acid to follow-up culture media. T increasing frequency of resistant organisms limi the usefulness of antibacterials including sulfonamides.** Measure sulfonamide blood levels a variations may occur; 20 mg/100 ml should be maximum total level.

Contraindications: Children below age 12; sulfonamide hypersensitivity; pregnancy at term an during nursing period; because Azo Gantanol co tains phenazopyridine hydrochloride it is contrai dicated in glomerulonephritis, severe hepatitis, uremia, and pyelonephritis of pregnancy with G. disturbances.

Warnings: Safety during pregnancy not establish Deaths from hypersensitivity reactions, agranulo tosis, aplastic anemia and other blood dyscrasia have been reported and early clinical signs (sore throat, fever, pallor, purpura or jaundice) may in dicate serious blood disorders. Frequent CBC an urinalysis with microscopic examination are rec ommended during sulfonamide therapy.

Precautions: Use cautiously in patients with impaired renal or hepatic function, severe allergy, bronchial asthma; in glucose-6-phosphate dehydrogenase-deficient individuals in whom dose-related hemolysis may occur. Maintain adequate fluid intake to prevent crystalluria and stone formation.

Adverse Reactions: *Blood dyscrasias* (agranulocytosis, aplastic anemia, thrombocytopenia, leukopenia, hemolytic anemia, purpura, hypopro thrombinemia and methemoglobinemia); *allergic reactions* (erythema multiforme, skin eruptions, Stevens-Johnson syndrome, epidermal necrolysis urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis); *G.I. reactions* (nausea, emesis, abdominal pains hepatitis, diarrhea, anorexia, pancreatitis and stomatitis); *CNS reactions* (headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo and insomnia); *miscellaneous reactions* (drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L. E. phenomenon). Due to certain chemical similarities with some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia. Cross-sensitivity with these agents may exist.

Dosage: Azo Gantanol is intended for the acute, painful phase of urinary tract infections. *Usual adult dosage:* 2 Gm (4 tabs) initially, then 1 Gm (2 tabs) B.I.D. for up to 3 days. If pain persists, causes other than infection should be sought. After relief of pain has been obtained, continued treatment with Gantanol (sulfamethoxazole) may be considered.

NOTE: Patients should be told that the orange-r dye (phenazopyridine HCl) will color the urine.

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"Whether we like it or not, we shall have to live with computers and use them without becoming tools of our tools."

An Introduction to Computer-Assisted Diagnosis

WAYNE W. DANIEL, Ph.D., *Atlanta**

THE OBSERVATION that we have for several years been in the midst of a computer revolution needs no documentation. Those of us living in developed societies are also aware of the fact that this revolution has permeated the health care field. The number of books written on the subject of computer applications in the health sciences is one indication of the impact that computer technology is having on these disciplines.[1-6]

Several journals are now devoted exclusively to the topic of computers in medicine and health related disciplines. Among those available are *Biological Cybernetics, Computer Medicine, Computer Programs in Biomedicine, Computers and Biomedical Research, Computers and Medicine, Computers in Biology and Medicine, Computer Technology and Biomedicine, International Journal of Biomedical Computing,* and *Journal of Clinical Computing.* In addition, one finds articles on computer applications in other journals aimed at health professionals. A recent issue of one health-oriented journal,[7] for example, was devoted exclusively to articles on various aspects of computers.

One area of computer application that was investigated early on, and one that continues to be explored by physicians, biostatisticians, and computer scientists, is that of computer-assisted diagnosis. A measure of the amount of attention computer-assisted diagnosis is receiving from writers in the health field is provided by the number of entries under that subject heading in *Index Medicus.*[8] Since 1973 more than 1100 such entries have appeared.

* Dr. Daniel is a professor in the Department of Quantitative Methods, Georgia State University, University Plaza, Atlanta, GA 30303.

Computer-Assisted Diagnosis

Boyle and Anderson[9] state that the basic idea behind computer-assisted diagnosis is to "use the data obtained from the clinical study of previously encountered patients to predict the likely diagnosis in a new patient presenting with another set of data (symptoms, clinical findings, etc.)." The efficiency of diagnosis by this method depends on the "correct formulation of a mathematical model to indicate meaningful associations between diseases and particular sets of symptoms."[10] The prediction of the likely diagnosis is accomplished by means of this formula which quantifies the relationship between a disease and a set of symptoms. Typically, a computer-assisted diagnosis system requires large data bases that provide the raw material for the repetitive operations the diagnostic procedure requires, and as Coles[11] has pointed out, it is with this type of task that the computer is especially successful. A computer does not become fatigued as it scans, organizes, and manipulates vast quantities of information. The physician often does become tired and is limited as to the amount of information he/she can absorb and use effectively. An objective of computer-assisted diagnosis, in the words of Lindley,[12] then, is "to make the diagnostic procedure more efficient by better handling of the data." Card[13] gives three reasons why the use of mathematics in conjunction with computers to make diagnoses should be explored: (1) Every physician must be trained anew to make a diagnosis, and regardless of the level of expertise attained, the skill dies with him/her; (2) the Western norm of individual therapeutic care is inapplicable in many parts of the

world; and (3) he suspects, without proof, that the traditional system is not always the most efficient.

One of the first to conceive of some mechanical aid to the diagnostic process was Nash.[14] His device consisted of a frame on the side of which were printed, in alphabetical order, a list of disease categories. On separate strips, one for each symptom, markers were placed in such a way that when the strips were inserted into the frame, the markers aligned with a disease category printed on the side of the frame. When several symptom strips had been inserted, the diseases aligned with the greatest number of markers were the ones that received attention as possible diagnoses for the patient whose symptoms were under study. Basically, then, the apparatus was able to indicate what diseases could account for any particular group of symptoms one wished to insert into the frame.

With the ascendancy of the computer, such basic ideas as that of Nash and others who had proposed various mechanical aids to diagnosis were adapted to this new tool. The emphasis now was placed on mathematical models and the dual abilities of the computer to store and rapidly process large amounts of data. Pioneers in these endeavors were Crooks et al.[15] and Ledley and Lusted[16] who analyzed the reasoning processes involved in medical diagnosis, proposed a mathematical model, and thereby laid the foundation for implementation of computer-assisted diagnosis. Hollingsworth[17] is credited with first using a computer to arrive at a diagnosis.

Methodology

Several mathematical-diagnostic models have been proposed since 1959. Among the techniques employed are Bayes's theorem, multivariate analysis, numerical taxonomy, likelihood ratio, and discriminant functions. Croft[18] points out that most of the mathematical methods that have been tested have very similar foundations. He notes that they all use variations of a mathematical technique called pattern recognition. Croft[18] used what he considered the 10 most common mathematical diagnostic models in a study to compare their relative diagnostic accuracies. Of all the methods employed in computer-assisted diagnosis, Bayes's theorem has been the most frequently used,[19-21] and in many comparative studies, this technique has been the superior performer.[18, 22, 23]

Bayes's theorem, which was derived more than 200 years ago by an English clergyman named Thomas Bayes,[24] is based on elementary laws of probability. It is sometimes called the theorem of inverse probability, because it enables one to determine the probability of some hypothesis (a patient has a certain disease, for example) given the presence of some condition (a particular symptom) when one knows the probability of the condition (symptom) given that the hypothesis is true (the patient has the disease). In addition to its use in computer-assisted diagnosis, Bayes's theorem has been used to predict hospital length of stay[25] and is one of the basic tools of modern decision theory.[26]

Example

A simple artificial example will serve to illustrate the procedure involved in computer-assisted diagnosis. Because of its frequent use and proven accuracy, Bayes's theorem is the diagnostic method chosen.

Suppose there are three possible diseases, D_1, D_2, and D_3, that are of concern. These diseases are assumed to be mutually exclusive; that is, if a patient has either one, he/she cannot have either of the other two. Past experience has shown that in the population of interest a good estimate of the probability of disease D_1 is 0.30. This probability may be written as

$$P(D_1) = 0.30$$

Typically, such a probability estimate is obtained from a large sample of patients of whom a certain number have the disease of interest. If we let N be the size of the total sample and N_1 be the number of subjects with disease D_1 in the total sample we compute $P(D_1)$ as

$$P(D_1) = \frac{N_1}{N}$$

This expression for a probability is based on the view that probability can be interpreted as the relative frequency of occurrence of an event or phenomenon. Thus, if N = 1,000 patients who have been evaluated and N_1 = 300 who have been found to have disease D_1, then

$$P(D_1) = \frac{300}{1000} = 0.30$$

for the total sample, and this figure can be used as an estimate of the probability of disease D_1 in the sampled population. Suppose, for our example, that it is known also that $P(D_2) = 0.20$, and $P(D_3) = 0.50$.

Now let us consider the symptoms that accompany these diseases. For the sake of simplicity, let us assume that there are five symptoms which we designate as S_1, S_2, S_3, S_4, and S_5. What is needed now, for each symptom, is the probability that the symptom occurs in a patient with any one of the diseases D_1, D_2, and D_3. These probabilities can be estimated from the same sample of data that served as a basis for computing the disease probabilities. For example, suppose, out of N_1 = 300 subjects with disease D_1, that n_1 = 75 had symptom S_1. Our estimate of the probability that a patient with disease D_1 would have symptom S_1 is computed as

$$P(S_1|D_1) = \frac{n_1}{N_1} = \frac{75}{300} = 0.25$$

The notation $P(S_1/D_1)$ is read as "the probability of symptom S_1, given that the subject has disease D_1."

Similar calculations might lead to the symptom-disease matrix given in Table 1.

TABLE 1
SYMPTOM-DISEASE MATRIX FOR ILLUSTRATIVE EXAMPLE

		Symptoms (S_j)				
Disease, D_i	$P(D_i)$	S_1	S_2	S_3	S_4	S_5
D_1	0.30	0.25	0.10	0.15	0.05	0.40
D_2	0.20	0.55	0.40	0.05	0.50	0.30
D_3	0.50	0.01	0.05	0.40	0.50	0.30

We may now calculate the probability that a patient with a given set of symptoms has disease D_1, the probability that he/she has disease D_2 and the probability that he/she has disease D_3. The formula is

$$P(D_i|S_1 \ldots S_j) = \frac{P(D_i)P(S_1|D_i)P(S_2|D_i) \ldots P(S_j|D_i)}{\Sigma P(D_i)P(S_1|D_i)P(S_2|D_i) \ldots P(S_j|D_i)}$$

which is known as Bayes's formula or Bayes's rule.[27]

Now suppose a patient presents with symptoms S_1, S_2, S_3, S_4, and S_5. The question to be answered is "Which of the three diseases (D_1, D_2 or D_3) does the patient have?" By the use of Bayes's formula and the data in Table 1, we compute the probability that the patient has each of the three diseases as follows:

$$P(D_1|S_1,S_2,S_3,S_4,S_5) = \frac{(0.30)(0.25)(0.10)(0.15)(0.05)(0.40)}{(0.30)(0.25)(0.10)(0.15)(0.05)(0.40) + (0.20)(0.55)(0.40)(0.05)(0.50)(0.30) + (0.50)(0.01)(0.05)(0.40)(0.50)(0.30)}$$

$$= \frac{0.0000225}{0.0003675} = 0.06$$

$$P(D_2|S_1,S_2,S_3,S_4,S_5) = \frac{(0.20)(0.55)(0.40)(0.05)(0.50)(0.30)}{0.0003675}$$

$$= \frac{0.0003300}{0.0003675} = 0.90$$

$$P(D_3|S_1,S_2,S_3,S_4,S_5) = \frac{(0.50)(0.01)(0.05)(0.40)(0.50)(0.30)}{0.0003675}$$

$$= \frac{0.0000150}{0.0003675} = 0.04$$

Since the computed probability associated with disease D_2 is the largest of the computed probabilities, we would conclude that this is the most likely diagnosis for the patient.

It is easy to see from this example that for even moderately large symptom-disease matrices, the calculations would be extremely tedious and time consuming. This is where the computer becomes important — as a rapid and accurate calculator. The symptom-disease matrix can be stored in a computer, and for each new patient, his/her symptoms can be entered into the computer which can then calculate the probabilities associated with each disease, choosing as the most likely diagnosis the one with the highest probability. Alternatively, the computer can be programmed to list each disease along with its computed probability, perhaps in order of the magnitude of the probabilities.

Areas of Application

Research in the area of application of computer-assisted diagnosis has been both voluminous and varied. Practically every medical specialty and disease category are represented in the research literature dealing with the subject. The following represent a sampling of the applications of computer-assisted diagnosis in various medical specialties and diagnostic groups.

Congenital Heart Disease. One of the earliest applications of computer-assisted diagnosis was the work of Warner et al.[28] in the area of congenital heart disease. These researchers used 22 symptoms in the diagnosis of 33 diseases (including normal). They found that when applied to 36 patients, the most probable diagnosis selected by Bayes's theorem agreed with the actual diagnosis made by physiologic studies and observations at surgery at least as often as did the most probable diagnosis selected by three experienced cardiologists on the basis of the same clinical information.

Goiter. Bouckaert and Beckers[29] used Bayes's theorem in the differential diagnosis of goiters in 149 cases observed in a department of internal medicine. Their symptom file consisted of 65 items. The diagnoses under consideration were thyroid cancer, toxic goiter (Grave's disease), nontoxic nodular goiter, nontoxic diffuse goiter, and toxic thyroid adenoma (Plummer's disease). The Bayesian procedure made a correct diagnosis in 94.7% of the cases.

Psychiatry. Hirschfeld et al.,[30] in an application of Bayes's theorem in the computer-assisted diagnosis of psychiatric disorders, evaluated 702 subjects making up four different samples. The eight diagnostic categories were paranoid schizophrenia, all other schizophrenia, selected neuroses and personality disorders, sexual deviation, alcoholism and drug dependence, psychophysiologic disorders,

transient situational disturbances, and no mental disorder. The diagnosis agreement rate between the clinician and the computer varied between about 40 and 70%, depending on the sample.

Pediatrics. Barness et al.[31] describe a computer-assisted diagnosis system in pediatrics. The system includes 1,500 different diagnoses and approximately 650 abnormal symptoms. Interaction with the computer is via remote teletypewriter terminal. In one study, the computer correctly diagnosed 90% of the cases.

Appendicitis. Graham[32] used a procedure based on Bayes's theorem to differentiate between acute and gangrenous or perforating appendicitis. The symptom list consisted of 186 items. The computer correctly diagnosed 260 (93.5%) of 278 cases of proved acute inflammation of the appendix. Out of 112 confirmed cases of perforating or gangrenous appendicitis, the computer correctly diagnosed 102 (91.1%).

Bronchial Carcinoma. Discriminant analysis was used by Rotte and Meiske[33] for the differential diagnosis of pulmonary lesions. The disease categories of interest were carcinomas, benign tumors, and tuberculomas. The symptom list consisted of 22 items, including signs from radiographic images. The computer correctly diagnosed 85% of 482 cases. When divided into two groups, the computer correctly classified 89% of the carcinomas and 90% of the benign diseases. When only patients with follow-up radiographs were presented, 89.3% of 362 cases were correctly classified. In this group, the accuracy rate was 90% for the carcinomas and 91% for the benign lesions.

Dyspepsia. Horrocks and de Dombal[34] used a variant of Bayes's theorem to diagnose 122 patients presenting with dyspepsia at an outpatient clinic. The symptom list was derived from 278 similar cases and consisted of 26 items obtained at interview. The computer's overall diagnostic accuracy with the 122 patients was 87.7%. When additional information from radiology, endoscopy, and gastric secretory tests were entered into the system, the overall diagnostic accuracy of the computer rose to 92.6%.

The Future

Two themes pervade the literature on computer-assisted diagnosis. They are (1) that computers are here to stay,[5, 35-37] and (2) that the computer will never replace the physician as the ultimate diagnostician.[16, 23, 38-41] Kugelmass summarizes the prevailing sentiment in his statement that, "Whether we like it or not, we shall have to live with computers and use them without becoming tools of our tools."[36]

There is, however, at least one commentator on the future of medicine and computers who sees the latter assuming a more dominant role. Silink[42] considers it not unrealistic to suppose that in the future computers will not only make diagnoses without human medical knowledge, but will make prescriptions, give advice to patients, and even write medical textbooks.

The most common prediction of the future of computer-assisted diagnosis is one in which the computer and the physician work as a team.[2, 13, 19, 43, 44] In this man-machine partnership, the computer will perform those tasks that it does best, such as rapidly and accurately processing large amounts of information; and the physician will contribute his/her unique talents, such as the ability to weigh the importance of various factors[42] and the ability to think creatively. It is expected that the physician will derive a number of benefits from such a partnership. Routine tasks can be delegated to the computer, thereby providing the physician with more time for "development and exercise of higher professional skills."[45] The techniques that are used in computer-assisted diagnosis can also be used in teaching medical diagnosis to medical students, interns, and residents.[5, 20, 46]

Limitations

It is a mistake to assume that the use of computers and mathematical models as aids to medical diagnosis is a simple procedure which, with the mere pushing of a button, achieves a state of perfection. The most enthusiastic advocates of computer-assisted diagnosis are not unaware of the limitations of this tool. Spencer and Vallbona[47] mention, among other problems, those of equipment failure and legal implications. Ross[48] expresses the fear that widespread application of computer-assisted diagnosis might lead to a tendency on the part of the physician to overestimate the capabilities of the computer and to some extent abrogate his/her responsibilities in the area of diagnosis. Boyle and Anderson[9] also discuss some additional limitations of computer-assisted diagnosis.

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Georgia Surgeons Oppose Mandatory Second Opinions

The members of the Georgia Chapter of the American College of Surgeons were asked to give their opinion regarding coercive or mandatory second opinions for elective surgery. Of the 271 who responded, 259 were opposed to the program. Eleven said that the program might be worthwhile under strict controls, with almost all stating the controls would have to be different from those suggested by various plans. One person was in favor of it.

At the January 1979 meeting of Hall County Medical Society, a resolution was adopted unanimously opposing any mandated second opinion programs.

PEP SEMINAR

"Private Enterprise Perspectives on Medicine"

May 26-27, 1979

Colony Square Hotel, Atlanta

Sponsored by the MAG
in cooperation with
the Chair of Private Enterprise at Georgia State University

Objective: To provide physicians with in-depth understanding of economic issues as they relate to everyday medical practice and to the role of the medical profession in American society.

Each county medical society has been invited to send two representatives to the seminar. In addition, all MAG members and spouses are encouraged to attend, as well as medical students and housestaff.

PROGRAM

May 26, 1979
Saturday, 1:00-5:00 p.m.

—"Who's Raising the Fuss and Why?"
—"The Marketplace of Medicine"
—"The Nature of Regulation"
—"Economic Analysis of Medical Issues"

5:00 MAG Reception

May 27, 1979
Sunday, 9:00-1:00 p.m.

—Concurrent Task Force Sessions
A. HMO: Medical Soviet or Social Good
B. The Supply and Distribution of Medical Services
C. The Reimbursement Dilemma: The Case of Medicaid in Georgia
D. The Medical Advertising Controversy
E. Is There a Right to Health?
—Plenary Session: Representatives of each task force will present the conclusions and rationales reached by their groups.

Faculty from Georgia State University: Michael H. Mescon, Ph.D., Holder of the Chair of Private Enterprise; Craig E. Aronoff, Ph.D., Assistant Professor of Management; Francis W. Rushing, Ph.D., Associate Professor of Economics.

CME Credit: As an organization accredited for continuing medical education, the Medical Association of Georgia designates this CME activity as meeting the criteria for 8 credit hours in Category 1 of the AMA's Physician's Recognition Award.

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PEP SEMINAR

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County Medical Society _____ My spouse will attend: yes ____ no ____

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Early diagnosis is crucial for the maintenance of a viable testicle.

Torsion of the Testicle

DONALD J. McKENZIE, M.D., *Thomasville**

TORSION OF THE TESTICLE, with its potential for resulting in orchiectomy or testicular atrophy if not corrected early, has been more commonly recognized than in previous years. Although this malady was first described in 1840, only 32 cases were reported in the world literature by 1901.[1]

Case Reports

From January 1965 to September 1978, 20 cases of torsion of the testicle were diagnosed at the John D. Archbold Memorial Hospital in Thomasville, Georgia. The patients ranged in age from 1 week to 28 years. The median age was 15.5 years.

Ninety-five percent of the patients presented with tender, swollen testicles (Table 1). Temperature elevations of at least 100.0°F were recorded for 35% of the patients, and 20% had urinalyses positive for white blood cells (WBC) (defined as 5 or more WBC/high power field). There were 15% with a history of a contralateral problem. Since one of the parameters for judging this was either an atrophied or nonexistent testicle on the opposite side, it is highly probable that the true incidence of contralateral problems in this study is much higher.

TABLE 1
CLINICAL FEATURES IN 20 CASES OF TORSION OF THE TESTICLE, JANUARY 1965-SEPTEMBER 1978, THOMASVILLE, GEORGIA

Clinical Features	Number of Cases
Tender, swollen testicle	19
Temperature elevation (100.0°F)	7
Urinalysis positive	4
History of contralateral problem	3
Orchiopexy	12
Orchiectomy	8
Urinary tract symptoms	1
Manual reduction of torsion	1

Orchiectomies were performed on 40% of the patients, with a finding of a non-viable testis. A manual reduction of the torsion was performed on one patient.

Torsion of the testicle can be confused with acute epididymitis; however, the latter entity is almost always associated with urinary tract symptoms and occurs very infrequently in adolescents. Only one patient in this study had urinary tract symptoms such as dysuria or urinary frequency.

Anomalous Anatomy

Based on a rather consistent finding at the time of exploration for torsion of the testicle, most authors conclude that the essential problem was related to high insertion of the tunica vaginalis on the spermatic cord, with a subsequently freely movable testicle suspended from a long pedicle.[2] This anomaly may frequently occur bilaterally. The clinical picture is that of a horizontally lying testicle.[3-4]

Diagnosis

Torsion of the testicle should be suspected where there is abrupt onset of testicular pain, with a paucity of urinary tract symptoms. The affected testicle may lie higher than its mate due to twisting of the spermatic cord. The Doppler ultrasonic flowmeter has been employed to delineate the existence of decreased blood flow in testicular torsion.[5] The benefits to be gained from this study, however, should be weighed against the consequences of a prolonged compromised blood supply.

* Department of Urology, John D. Archbold Memorial Hospital, Thomasville, GA 31792.

It is therefore important to realize the relatively high incidence of torsion of the testicle in adolescent males, especially in contrast to the low incidence of epididymo-orchitis in this age group with which it may be confused.

Surgical Correction

Surgery consists of exposure of the affected testicle, manual de-rotation, and fixation of the testis to the scrotal wall with a row of catgut sutures. Since freely rotating testes have further rotated following placement of only one or even several sutures, a row of sutures is specifically recommended.

At the time of surgery, the viability of the testicle may not be obvious. Sertoli cells, significant in the role of spermatogenesis, are particularly susceptible to a compromised blood supply. They may be somewhat impaired. Leydig cells, which are instrumental in the production of hormones, appear to be less critically dependent on a temporarily compromised blood supply and may be functional even when Sertoli cells are not.

Conclusion

Torsion of the testicle is not an uncommon entity in adolescents. Early diagnosis of this malady is essential for maintenance of a viable testicle. The most common differential diagnosis is epididymo-orchitis, which is rare in adolescents and is usually associated with urinary tract symptoms. Surgery should not be delayed for a trial of antibiotic therapy.

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Gonorrhea: Recommended Treatment Schedules,* 1979

Note: Physicians are cautioned to use no less than the recommended dosages of antibiotics. The major change from the 1974 published treatment schedule is that there are now four drug regimens which can be used for the treatment of uncomplicated gonorrhea.

Uncomplicated Gonococcal Infections in Men and women

Drug Regimens of Choice

Aqueous procaine penicillin G (APPG): 4.8 million units injected intramuscularly at 2 sites, with 1.0 g of probenecid by mouth. **OR**

Tetracycline hydrochloride:† 0.5 g by mouth 4 times a day for 5 days (total dosage 10.0 g). Other tetracyclines are not more effective than tetracycline hydrochloride. All tetracyclines are ineffective as a single-dose therapy. **OR**

Ampicillin or amoxicillin: Ampicillin, 3.5 g, or amoxicillin, 3.0 g, either with 1 g probenecid by mouth. Evidence shows that these regimens are slightly less effective than the other recommended regimens.

Patients who are allergic to the penicillins or probenecid should be treated with oral tetracycline as above. Patients who cannot tolerate tetracycline may be treated with spectinomycin hydrochloride, 2.0 g, in 1 intramuscular injection.

Special Considerations

Single-dose treatment is preferred in patients who are unlikely to complete the multiple-dose tetracycline regimen. The APPG regimen is preferred in men with anorectal infection.

Pharyngeal infection is difficult to treat. High failure rates have been reported with ampicillin and spectinomycin.

Tetracycline treatment results in fewer cases of postgonococcal urethritis in men. It may eliminate coexisting chlamydial infections in men and women.

Patients with incubating syphilis (seronegative, without clinical signs of syphilis) are likely to be cured by all the above regimens except spectinomycin. All patients should have a serologic test for syphilis at the time of diagnosis.

Patients with gonorrhea who also have syphilis or are established contacts of syphilis patients should be given additional treatment appropriate to the stage of syphilis.

Treatment of Sexual Partners

Men and women who have been exposed to gonorrhea and are found to have positive cultures should be treated at once with one of the regimens above.

Follow-up

Follow-up specimens should be obtained from the infected site(s) 3-7 days after completion of treatment. Specimens should be obtained from the anal canal of all women who have been treated for gonorrhea.

Treatment Failures

The patient who fails therapy with penicillin, ampicillin, amoxicillin, or tetracycline should be treated with 2.0 g of spectinomycin intramuscularly.

Most recurrent infections after treatment with the recommended schedules are due to *reinfection* and indicate a need for improved contact tracing and patient education. Since infections by penicillinase (B-lactamase)-producing *Neisseria gonorrhoeae* is a cause of treatment failure, post-treatment isolates should be tested for penicillinase production.

* These recommendations were compiled by the Center for Disease Control in Atlanta and published in Vol. 28, No. 2, of the *Morbidity and Mortality Weekly Report*. The recommendations were established after deliberation with these therapy consultants: HC Neu, MD, College of Physicians and Surgeons, Columbia University; EH Braff, MD, San Francisco Dept of Public Health; G Cunningham, MD, Southwestern Medical School, Dallas; KK Holmes, MD, PhD, USPHS Hospital, Seattle; F Judson, MD, Dept of Health and Hospitals, Denver; W McCormack, MD, State Laboratory Institute, Boston; EM Mears, Jr, MD, New England Medical Center, Boston; JD Nelson, MD, Southwestern Medical School, Dallas; M Nelson, MD, Orange County, Calif; SM Sgroi, MD, Suffield, Conn.; F Sparling, MD, School of Medicine, The University of North Carolina, Chapel Hill; Lt. Col. EC Tramont, Walter Reed Army Medical Center, Washington, D.C.

† Food and some dairy products interfere with absorption. Oral forms of tetracycline should be given 1 hour before or 2 hours after meals.

Not Recommended

Although long-acting forms of penicillin (such as benzathine penicillin G) are effective in syphilotherapy, they have *no* place in the treatment of gonorrhea. Oral penicillin preparations such as penicillin V are not recommended for the treatment of gonococcal infection.

Penicillinase-Producing *Neisseria Gonorrhoeae* (PPNG)

Patients with uncomplicated PPNG infections and their sexual contacts should receive spectinomycin, 2.0 g, intramuscularly in a single injection. Because gonococci are very rarely resistant to spectinomycin and reinfection is the most common cause of treatment failure, patients with positive cultures after spectinomycin therapy should be re-treated with the same dose.

A PPNG isolate that is resistant to spectinomycin may be treated with cefoxitin, 2.0 g, in a single intramuscular injection, with probenecid, 1.0 g, by mouth.

Treatment in Pregnancy

All pregnant women should have endocervical specimens cultured for gonococci as an integral part of the prenatal care at the time of the first visit. A second specimen late in the third trimester should be obtained from women at high risk of gonococcal infection.

Drug regimens of choice are APPG, ampicillin, or amoxicillin, each with probenecid as described above.

Women who are allergic to penicillin or probenecid should be treated with spectinomycin.

Refer to the sections on acute salpingitis and disseminated gonococcal infections for the treatment of these conditions during pregnancy. Tetracycline should not be used in pregnant women because of potential toxic effects for mother and fetus.

Acute Salpingitis (Pelvic Inflammatory Disease)

There are no reliable clinical criteria to distinguish gonococcal from nongonococcal salpingitis. Endocervical cultures for *N. gonorrhoeae* are essential. Therapy should be initiated immediately.

Hospitalization

In the following situations, hospitalization should be strongly considered: uncertain diagnosis, in which surgical emergencies such as appendicitis and ectopic pregnancy must be excluded; suspicion of pelvic abscess; severe illness; pregnancy; inability of patient to follow or tolerate an outpatient regimen; or failure of patient to respond to outpatient therapy.

Antimicrobial Agents

*Outpatients: Tetracycline:** 0.5 g, taken orally 4 times a day for 10 days. This regimen should not be used for pregnant patients. **OR** *APPG:* 4.8 million units intramuscularly, ampicillin, 3.5 g, or amoxicillin, 3.0 g, each with probenecid, 1.0 g. Either regimen is followed by ampicillin, 0.5 g, or amoxicillin, 0.5 g, orally 4 times a day for 10 days.

Hospitalized patients: Aqueous crystalline penicillin G: 20 million units given intravenously each day until improvement occurs, followed by ampicillin, 0.5 g, orally 4 times a day to complete 10 days of therapy. **OR** *Tetracycline:** 0.25 g, given intravenously 4 times a day until improvement occurs, followed by 0.5 g orally 4 times a day to complete 10 days of therapy. This regimen should not be used for pregnant women. The dosage may have to be adjusted if renal function is depressed.

Since optimal therapy for hospitalized patients has not been established, other antibiotics in addition to penicillin are frequently used.

Special Considerations

Failure of the patient to improve on the recommended regimens does not indicate the need for stepwise additional antibiotics, but requires clinical reassessment.

The intrauterine device is a risk factor for the development of pelvic inflammatory disease. The effect of removing an intrauterine device on the response of acute salpingitis to antimicrobial therapy and on the risk of recurrent salpingitis is unknown.

Adequate treatment of women with acute salpingitis must include examination and appropriate treatment of their sex partners because of their high prevalence of nonsymptomatic urethral infection. Failure to treat sex partners is a major cause of recurrent gonococcal salpingitis.

Follow-up of patients with acute salpingitis is essential during and after treatment. All patients should be recultured for *N. gonorrhoeae* after treatment.

Acute Epididymitis

Acute epididymitis can be caused by *N. gonorrhoeae, Chlamydia,* or other organisms. If gonococci are demonstrated by Gram stain or culture of urethral secretions, treatment should be APPG, 4.8 million units, ampicillin, 3.5 g, or amoxicillin, 3.0 g, each with probenecid, 1.0 g. Either regimen is followed by ampicillin, 0.5 g, or amoxicillin, 0.5 g, orally 4 times a day for 10 days, **OR** tetracycline,* 0.5 g, orally 4 times a day for 10 days.

If gonococci are not demonstrated, the above tetracycline regimen should be used.

* Food and some dairy products interfere with absorption. Oral forms of tetracycline should be given 1 hour before or 2 hours after meals.

Disseminated Gonococcal Infection

Treatment Schedules

There are several, equally effective treatment schedules in the arthritis-dermatitis syndrome. These include the following.

Ampicillin/amoxicillin: ampicillin, 3.5 g, or amoxicillin, 3.0 g, orally, each with probenecid, 1.0 g, followed by ampicillin 0.5 g, or amoxicillin, 0.5 g, 4 times a day orally for 7 days. **OR**

*Tetracycline:** 0.5 g, orally 4 times a day for 7 days. Tetracycline should not be used for complicated gonococcal infection in pregnant women. **OR**

Spectinomycin: 2.0 g, intramuscularly twice a day for 3 days (treatment of choice for disseminated infections caused by PPNG). **OR**

Erythromycin: 0.5 g, orally 4 times a day for 7 days. **OR**

Aqueous crystalline penicillin G: 10 million units intravenously per day until improvement occurs, followed by ampicillin, 0.5 g, 4 times a day, to complete 7 days of antibiotic treatment.

Special Considerations

Hospitalization is indicated in patients who may be unreliable, have uncertain diagnosis, or have purulent joint effusions or other complications.

Open drainage of joints other than the hip is not indicated. Intra-articular injection of antibiotics is unnecessary.

Meningitis and Endocarditis

Meningitis and endocarditis caused by the gonococcus require high-dose intravenous penicillin therapy. In penicillin-allergic patients with endocarditis, desensitization and administration of penicillin are indicated. Chloramphenicol may be used in penicillin-allergic patients with meningitis.

Gonococcal Infections in Pediatric Patients

With gonococcal infections in children beyond the newborn period, the possibility of sexual abuse must be considered. Genital, anal, and pharyngeal specimens should be obtained from all patients before antibiotic treatment. Appropriate specimens should be obtained from individuals who have had contact with the child.

Prevention of Gonococcal Ophthalmia

When required by state legislation or indicated by local epidemiologic considerations, effective and acceptable regimens for prophylaxis of neonatal gonococcal ophthalmia include ophthalmic ointment or drops containing tetracycline or erythromycin **OR** a 1% silver nitrate solution.

Special Considerations

Bacitracin is not recommended. The value of irrigation after application of silver nitrate is unknown.

Management of Infants Born to Mothers with Gonococcal Infection

The infant born to a mother with gonorrhea is at high risk of infection and requires treatment with a single intravenous or intramuscular injection of aqueous crystalline penicillin G, 50,000 units to full-term infants or 20,000 units to low-birth-rate infants. Topical prophylaxis for neonatal ophthalmia is not adequate treatment. Clinical illness requires additional treatment.

Neonatal Disease

Gonococcal Ophthalmia

Patients should be hospitalized and isolated for 24 hours after initiation of treatment. Untreated gonococcal ophthalmia is highly contagious. Aqueous crystalline penicillin G, 50,000 units/kg/day, in 2 doses intravenously should be administered for 7 days. Saline irrigation of the eyes should be performed as needed. Topical antibiotic preparations alone are not sufficient or required when appropriate systemic antibiotic therapy is given.

Complicated Infection

Patients with arthritis and septicemia should be hospitalized and treated with aqueous crystalline penicillin G, 75,000 to 100,000 units/kg/day, intravenously in 2 or 3 divided doses for 7 days. Meningitis should be treated with aqueous crystalline penicillin G, 100,000 units/kg/day, divided into 3 or 4 intravenous doses, and continued for at least 10 days.

Childhood Disease

Children who weigh 100 lbs (45 kg) or more should receive adult regimens. Children who weigh less than 100 lbs should be treated as follows.

Uncomplicated Disease

Uncomplicated vulvovaginitis, urethritis, proctitis, or pharyngitis can be treated at 1 visit with amoxicillin, 50/kg, orally with probenecid, 25 mg/kg (maximum 1.0 g), **OR** with aqueous procaine penicillin G, 100,000 units/kg, intramuscularly plus probenecid, 25 mg/kg (maximum 1.0 g).

Special Considerations

Topical and/or systemic estrogen therapy are of no benefit in vulvovaginitis. Long-acting penicillins, such as benzathine penicillin G, are not effective. All patients should have follow-up cultures done, and the source of infection should be identified, examined, and treated.

Gonococcal Ophthalmia

Ophthalmia in children is treated as in neonates,

but the dose of penicillin is increased to 100,000 units/kg/day intravenously.

Complicated Infections

Patients with peritonitis or arthritis require hospitalization and treatment with aqueous crystalline penicillin G, 100,000 units/kg/day, intravenously for 7 days. Aqueous crystalline penicillin G, 250,000 units/kg/day, intravenously in 6 divided doses for at least 10 days, is recommended for meningitis.

Allergy to Penicillins

Children who are allergic to penicillins should be treated with spectinomycin, 40 mg/kg, intramuscularly. Children older than 8 years may be treated with tetracycline, 40 mg/kg/day, orally in 4 divided doses for 5 days. For treatment of complicated disease, the alternative regimens recommended for adults may be used in appropriate pediatric dosages.

PSRO Nets $5 Million Savings for 1977

Medicare beneficiaries in areas of the country served by Professional Standard Review Organizations (PSROs) are spending fewer days in the hospital than beneficiaries in areas without PSROs.

An evaluation report prepared by Department of Health, Education, and Welfare (HEW) says the PSRO program, under attack a year ago by the Administration, has become "an effective partner . . . in the HEW campaign to reduce unnecessary costs while assuring high quality care," according to HEW Secretary Califano.

In the 93 areas served by PSROs, Medicare beneficiaries used 1.5 percent fewer days of hospital care than they would have used without PSROs, a savings of about 55 days of care per 1,000 beneficiaries, according to the report.

HEW estimated that PSROs saved $50 million in 1977 by eliminating unnecessary days in the hospital. The 96 PSROs spent $45 million that year to review hospital care, producing a net savings of $5 million.

STATEWIDE CONFERENCE ON HEALTH PLANNING

MAY 19, 1979

TERRACE GARDEN INN, ATLANTA

Sponsored by the MAG Health Planning Committee,
J. W. "Red" Chambers, Chairman

PURPOSE: To organize Health System Agency (HSA)/Physician Task Forces in each of Georgia's Health Service Areas; to promote grass roots physician involvement in health planning in Georgia.

FEATURED SPEAKERS: John B. Coleman, M.D., First Vice-President, Minnesota Medical Association. Doctor Coleman will discuss the "Minnesota Experience" which has been nationally recognized as a model for stimulating widespread physician interest in the health planning process. John D. Watson, M.D., from Columbus served as President of the HSA of Central Georgia for 3 years. He will discuss health planning in Georgia and the need for physicians to become involved in HSA activities.

PARTICIPANTS: MAG members of HSA Boards and county medical society representatives appointed by each county medical society.

For more information contact Bert Franco at MAG Headquarters, toll free (1-800-282-0224).

"More than ever, I am convinced that nationalized health care is **not** *inevitable in the U.S."*

Canada's Health Care Delivery System

JOHN P. HEARD, M.D., ***Decatur****

Introduction

THE CANADIAN health care system, operating for 20 years with government-sponsored hospital coverage and 10 years with government-sponsored doctor coverage, is a nearby form of socialized medicine we can conveniently observe. I was able to study it at a 5-day AMA-sponsored program in Toronto in November of 1978. I have consistently claimed that the AMA is too tolerant of government intrusion into the health field, and I must admit that I carried my prejudice across the border. I discovered, however, that Canadians are receiving good medical care now, although problems related to cost have manifested, and no workable solutions have yet been devised to correct them.

Canadian Government, Economy, and Society

"Free" health care was a political promise in Canada as in any nation that offers comprehensive coverage, but it was easy to fit into the Canadian social structure, since their governmental economy is truly a socialistic one — about half-way between Great Britain's socialism and our predominately free enterprise economy. Apparently, the 1929 depression hit harder in Canada, followed by the drought of the 1930's, and many Canadians, including doctors, were on welfare. The development of prepayment plans and insurance programs, many of them sponsored by doctors at that time, made shifting to a government-controlled program an easy step. Moreover, physicians did not anticipate any trouble.

The 10 provinces and two territories constitute their principal form of government; it is much more cohesive and effective than our 50 state governments. Their national health care system is rather loosely defined and made up of 12 separate provincial and territorial plans supported largely by taxes.

Canada is larger geographically than the United States but has only one-tenth the population we do. Its economy fluctuates coincidentally with ours, except that its ups and downs are correspondingly higher and lower. Hence inflation, high taxes, and the dominance of labor unions have a greater influence in Canada.

History of National Health Insurance (NHI) Inception

In the 1940's, several provinces developed successful health insurance programs to cover hospital expenses, and this eventually led to a national program which was warmly received by everyone in 1958. Costs were not too high then, and with the economy good, the government made political "hay." The hospitals were happy with their new financial position, and so were the doctors, because they could get paid more easily, since the patients were not responsible for paying their hospital bills.

The hospital program was so popular that physician reimbursement was instituted 10 years later in 1968. This was welcomed by everyone except the doctors, but they were not well organized and resisted ineffectually. Any opposition by individual physicians was soon squelched as physicians' incomes jumped the first year. But as inflation has since risen twice as fast as the government increases in physicians' fees, the doctor is now really hurting financially.

* Dr. Heard is a family physician. His address is 231 E. Ponce de Leon Ave., Decatur, GA 30030.

How Financed

The provincial systems are financed mostly through general taxation, 50% by the federal government and 50% by the provinces. It is the largest single expenditure in both budgets, being 30% of the provincial budget in Ontario, which also charges $456 per family in addition to the budgetary expenditure. The only use fee (or deductible) charge is $4 a day in British Columbia, so there is no barrier to overutilization.

How Spent

About 65% of the budget goes for hospitals, 22% to physicians, and 13% for other expenses. Hospitals include short and long-term institutions. Each hospital is given a predetermined amount of money and can allocate it any way it sees fit on the services it is permitted to offer. Some hospitals have been closed by government order, and others have had specific services closed in the manner of certain Health Systems Agency (HSA)-like activities. Education and research are each budgeted a set amount.

The doctor has a little more freedom. He can elect to opt-in or opt-out of the system (take assignment or not), just as we do with Medicare. He must commit totally to one way or the other, however, and cannot decide on a case by case basis as we do. By law, each provincial medical association must negotiate a fee scale for its province annually, and the government will reimburse the patient or pay the doctor 90% of this amount. If the doctor opts-in, and 85% do, all the payments come to him in one monthly government check, and he cannot bill extra. If he opts-out, he bills and collects from the patient any amount he deems reasonable, and the patient is reimbursed the same 90% of the fee scale.

The term "negotiated fee scale" is a misnomer, since the government enters the negotiations with a predetermined amount of money it will spend for doctors' fees. It is then divided among the various specialities. This battle for the money naturally creates friction among the various specialty groups.

Problems Encountered and Anticipated

Canadian doctors early on predicted overutilization, cost overruns, deterioration of quality, and eventual rationing of care (the same outcomes we forecast), and all of these predictions are gradually being realized. They have been accentuated lately as Canada's economy, like ours, has gone from plentiful to lean years. The situation is becoming more critical.

National budget overruns that make our's look small by comparison threaten their national economy, and health funding is headed down a rocky road.

Problems of Access, Quality, and Costs

Accessibility, quality, and costs are mutually exclusive in Canada just as in any country. With the lowering of all barriers to health care, costs have increased tremendously, just as the medical profession predicted, creating ever new attempts to hold the line on budgets.

Acute-care hospital beds have been cut back from 5/1000 population to 4/1000 population, and a target of 3.5/1000 beds has been announced. Hospitals see any real increase in their budget eaten up by increased costs of administration, which further reduces services to patients.

The same fate has struck medical education and research. Their stipends are not keeping abreast of inflation either, causing medical school enrollment and residency programs to be cut back. Volunteer teaching has declined sharply, since the private doctor cannot afford to take time out of his practice to teach. Research grants are smaller, for shorter periods of time, with no allowance for overhead.

Payments to doctors have increased at an annual rate of 4%, while the country's inflation has grown by 8%, and the average wage increase in Canada is 11% per year. This deterioration in the doctors remuneration under NHI has forced the doctor to work harder, to see more patients, and subsequently to allot less time for each patient. Many doctors have left Canada, amounting to nearly 1,000 in 1978, and I am told these are their best people who refuse to take this denigration of their value.

Problems for Patients

Canadians are generally happy with their national health program so far. They are used to high taxes and see this as a "free" service of government and have no inside view of the problems ahead. Their only real complaint today is that the doctor does not give them as much time as before, but the personal touch is slipping, as much medical care is rendered in emergency rooms by doctors who are strangers to the patients with no continuity of care.

Problems for Government

The government is unhappy with the cost of the system, and this unhappiness is compounded when they study the solutions to the cost problem. So the government blames the doctors for costs getting out of hand. But as one speaker pointed out, "Costs have not gotten out of hand. It's in the government's hands, and they can budget whatever they like for health care."

Administrative costs are impossible to determine, as no one will give accurate facts. In each province, administration is budgeted at about 6%, but this is not the whole story. Much paperwork is done in

doctors' offices and hospitals, and there is a huge bureaucracy for health care in each province financed by the tax dollar, not unlike our Department of Health, Education, and Welfare.

Problems for Hospitals

Hospitals are generally satisfied at present, as they have no debt, though each hospital is saddled with markedly increased salaries for administration as they try to justify their total budget and divide up the dollars within the hospital. The wage-price spiral of inflation has increased their expenses, and their previous sources of contributions ignore them since they are state supported. Fortunately, during the good economic years many new facilities were built. There are now *no* funds for capital improvements, and *no* depreciation of buildings is included in the budgets. The cost of capital outlays for buildings will hit hard in about 10-20 years.

Problems for Doctors

Doctors' feelings run the full spectrum from contentment to anger, the more angry ones often being the more independent ones in private practice. The medical societies have urged the doctors to opt-out of the system so as to be more independent, but the security of a guaranteed check each month keeps 85% of the physicians taking assignment of the designated fees. As government fee increases fall more and more behind inflation, however, further economic pressure may force more doctors to opt-out which may in turn force the government to opt-in *all* doctors in a form of conscription.

Inflation in Canada has risen twice as fast as the government increases in physician's fees.

Physicians have gone on strike in two provinces of Canada. In 1972, the doctors of Saskatchewan struck for 23 days, providing only emergency services, in order to win the right to bill the patient. In the province of Quebec, doctors struck, and the next day the Parliament of Quebec ordered them to work or be jailed. This was so upsetting, some doctors who were out of the country never returned and settled elsewhere. Canada has no Bill of Rights, a fact pointed out to me several times to assure me American doctors would fare better in a strike and could not be conscripted nearly as easily as Canadian doctors.

Doctors also resent the government encroachment into clinical decisions. It promises to get worse, since Canada is now setting up District Health Councils dominated by consumers which will do what our Professional Standard Review Organization's and HSA's are doing.

Advice to U.S. Doctors

Based on their assumption that NHI is inevitable in the states, all speakers at the Toronto meeting had the same advice: be united, be politically active, and don't make the same mistakes they did. Yet I feel that following their advice is an excellent way to never have NHI.

Canada's mistakes, which they urged us not to copy, are the same ones we predict here. First, dollar coverage cannot be financed by any nation no matter how wealthy. "Free" medical care is not really "free," and the Canadian government is sooner or later going to have to tell the people to stop abusing it, raise taxes, or ration care. Right now they are feeling their way by trying a little of all three approaches.

Some practitioners had predicted that an alliance with government would not work, but most admitted they learned this the hard way.

Physicians were not as divided about NHI at the outset as was the case in England, but they are getting more so as teachers, researchers, and all specialties fight among themselves for the bone, the budgeted dollar. Unfortunately, this scrapping for the government dollar has already started among us in the states.

Some practitioners had predicted that an alliance with government would not work, but most admitted they learned this the hard way and warned us over and over that political clout was the only thing politicians understand.

"Never help them! Never think you can do the job of review or administration better than they will do. They will not let you, and you will lose your integrity by trying. Let them assume the responsibility and explain the inevitable failure."

Their loudest warning was to maintain professional freedom, the freedom to practice where we wish, the freedom to see or decline patients, and the freedom to charge and bill the patient directly. Canadian doctors feel they have lost this battle already. They are convinced that when enough doctors opt-out of the system, say 30%, the government will then withdraw this privilege and conscription will be the order of the day and all doctors will be on the government payroll. Do not fall into this trap, they warn.

However, many Canadian doctors now see this as their only economic out. They will then be civil servants with paid vacations, retirement, sick pay, and a 35-hour work week. But what will this do to access to care? What will this do to the doctor personally and his free spirit? Most importantly, what will this do to the patient and his medical care?

Doctors are no longer the highest paid professional in Canada today; lawyers and dentists are. However, the economic story we should tell is not about annual income but hourly income. Ten years ago the doctors' hourly income was eight times that earned by the average wage earner, today it is only four times. It has decreased from four times the salaries of a policeman to only twice his pay, and many skilled craftsmen earn more than doctors.

But loss of income ranks third in the reasons why doctors are leaving Canada. First, the loss of status and self-esteem is reflected in the increasing demands by a population that considers medical care to be both free and their right, and physicians as public servants to provide it. Doctors are annoyed with all the criticism and accusations concerning a financial plight they did not create.

Second, there is the frustration of dealing with the federal and provincial governments over minutiae. Doctors resent the harassment over clinical decisions and practice patterns. Canada also publishes the names of all physicians billing the government over $100,000 a year in the media.

If we can avoid NHI in the United States for 5 more years, no one will be able then to point to Canada as a paragon of ideal health care delivery.

It surprised me that no big point was made that doctors should give of their time to fight government takeover. We were advised to put up our money and our time but mostly our money. This should be used to hire better qualified people — leaders, research economists, and public relations people to educate the doctors as well as the public. "But do it now and plan on a $1,000 investment per doctor, because after the government takes over, you cannot afford it. And tell the real message, that the patient is the loser in nationalized medicine."

We were also warned of medical leadership that enjoys the prestige of association with elected officials. Their experience indicated this type of doctor will do anything to stay in office and anything to placate government so as to maintain personal contact in high places and thus feed his own ego. Many doctors feel this was their weakest link in their battle to maintain professional freedom. "Now we are electing fighters to office in our societies but I'm afraid the battle is over."

Conclusions

1. A good level of health care is still being delivered and appreciated by the people but at considerable costs.
2. Rationing by any method to save money may bring serious political problems, but health care as a "right" is being questioned in Canada and being talked of as a "privilege."
3. Canadians are traditionally more complacent, more socialistic, and more dependent on the government and will take all this better than our citizens.
4. Most physicians are unhappy with government controls, but their actions vary from resignation to leaving the country, almost 1,000 in 1978. More than 15,000 Canadian physicians now have a U.S. license.
5. Canadian physicians are poorly organized and constantly urge us to stay united and encourage our organizations to fight government control at every level.
6. Financially, Canadian medicine is reaching a sharp turn in the road. Expenditures are still rising, and severe controls are on the way.
7. My most important observation is that Canada will not negotiate this turn in the road. If we can avoid NHI in the United States for 5 more years, no one will be able then to point to Canada as a paragon of ideal health care delivery.
8. Canada entered this program when their economy was good, and it is now having trouble. For the U.S. to consider NHI with our present annual deficit is absurd.
9. More than ever, I am convinced that nationalized health care in the U.S. is not inevitable.
10. It is impossible for me to understand how the AMA can hear this comprehensive study of NHI in Canada, with the problems it faces, and consider submitting a proposal for NHI to our Congress without betraying not only the doctors it represents but also our patients.

The trained nurse has given nursing the human, or shall we say, the divine touch, and made the hospital desirable for patients with serious ailments regardless of their home advantages.

Charles H. Mayo (1865-1939): *Collected Papers of the Mayo Clinic and Mayo Foundation* 13:1242, 1921

When the indications surface...



NEOSPORIN® Ointment

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Each gram contains: Aerosporin® (Polymyxin B Sulfate) 5,000 units, bacitracin zinc 400 units, neomycin sulfate 5 mg (equivalent to 3.5 mg neomycin base), special white petrolatum qs; in tubes of 1 oz and 1/2 oz and 1/32 oz (approx.) foil packets.

INDICATIONS: *Therapeutically,* (as an adjunct to systemic therapy when indicated), for topical infections, primary or secondary, due to susceptible organisms, as in: infected burns, skin grafts, surgical incisions, otitis externa; primary pyodermas (impetigo, ecthyma, sycosis vulgaris, paronychia); secondarily infected dermatoses (eczema, herpes, and seborrheic dermatitis); traumatic lesions, inflamed or suppurating as a result of bacterial infection. *Prophylactically,* the ointment may be used to prevent bacterial contamination in burns, skin grafts, incisions, and other clean lesions. For abrasions, minor cuts and wounds accidentally incurred, its use may prevent the development of infection and permit wound healing.

CONTRAINDICATIONS: This product is contraindicated in those individuals who have shown hypersensitivity to any of its components. Do not use in the eyes or in the external ear canal if the eardrum is perforated.

WARNING: Because of the potential hazard of nephrotoxicity and ototoxicity due to neomycin, care should be exercised when using this product in treating extensive burns, trophic ulceration and other extensive conditions where absorption of neomycin is possible. In burns where more than 20 percent of the body surface is affected, especially if the patient has impaired renal function or is receiving other aminoglycoside antibiotics concurrently, not more than one application a day is recommended.

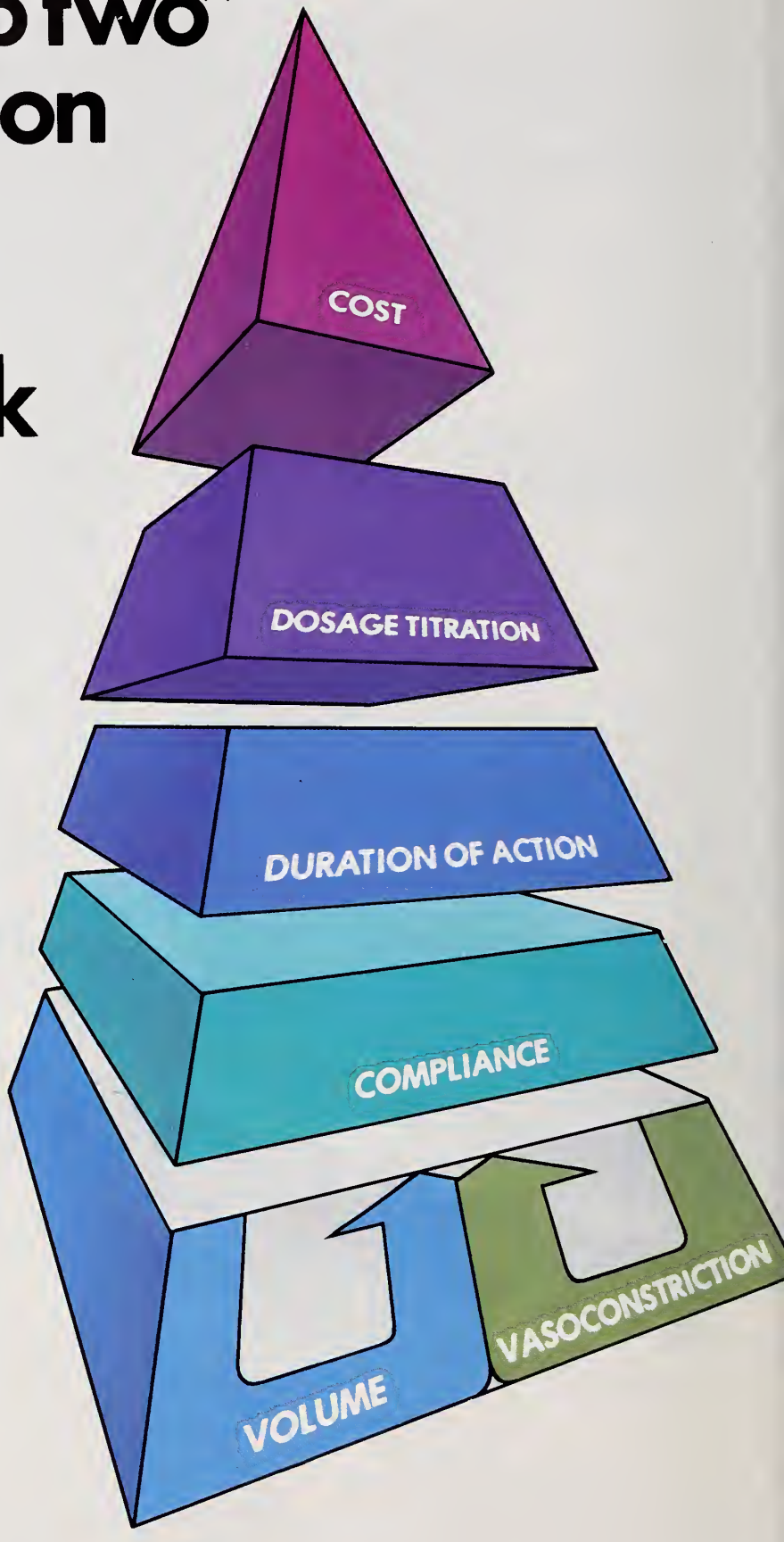
When using neomycin-containing products to control secondary infection in the chronic dermatoses, it should be borne in mind that the skin is more liable to become sensitized to many substances, including neomycin. The manifestation of sensitization to neomycin is usually a low grade reddening with swelling, dry scaling and itching; it may be manifest simply as failure to heal. During long-term use of neomycin-containing products, periodic examination for such signs is advisable and the patient should be told to discontinue the product if they are observed. These symptoms regress quickly on withdrawing the medication. Neomycin-containing applications should be avoided for that patient thereafter.

PRECAUTIONS: As with other antibacterial preparations, prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs.

ADVERSE REACTIONS: Neomycin is a not uncommon cutaneous sensitizer. Articles in the current literature indicate an increase in the prevalence of persons allergic to neomycin. Ototoxicity and nephrotoxicity have been reported (see Warning section).

Complete literature available on request from Professional Services Dept. PML.

As in a pyramid, sound "step two" hypertension therapy requires every block



Saluron®
(hydroflumethiazide 50 mg.)

Salutensin®
(hydroflumethiazide 50 mg./reserpine 0.125 mg.)

Salutensin-Demi™
(hydroflumethiazide 25 mg./reserpine 0.125 mg.)

the family of antihypertensives completing the therapeutic pyramid

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According to a recent study,[1] Salutensin® (hydroflumethiazide 50 mg./reserpine 0.125 mg.) was the most economical "step two" therapy...about ⅓ the cost of a day's supply of *thiazide* + *methyldopa* or *thiazide* + *propranolol*.[2]

Dosage titration

Salutensin contains the recommended effective doses of both its components, requiring minimal titration.

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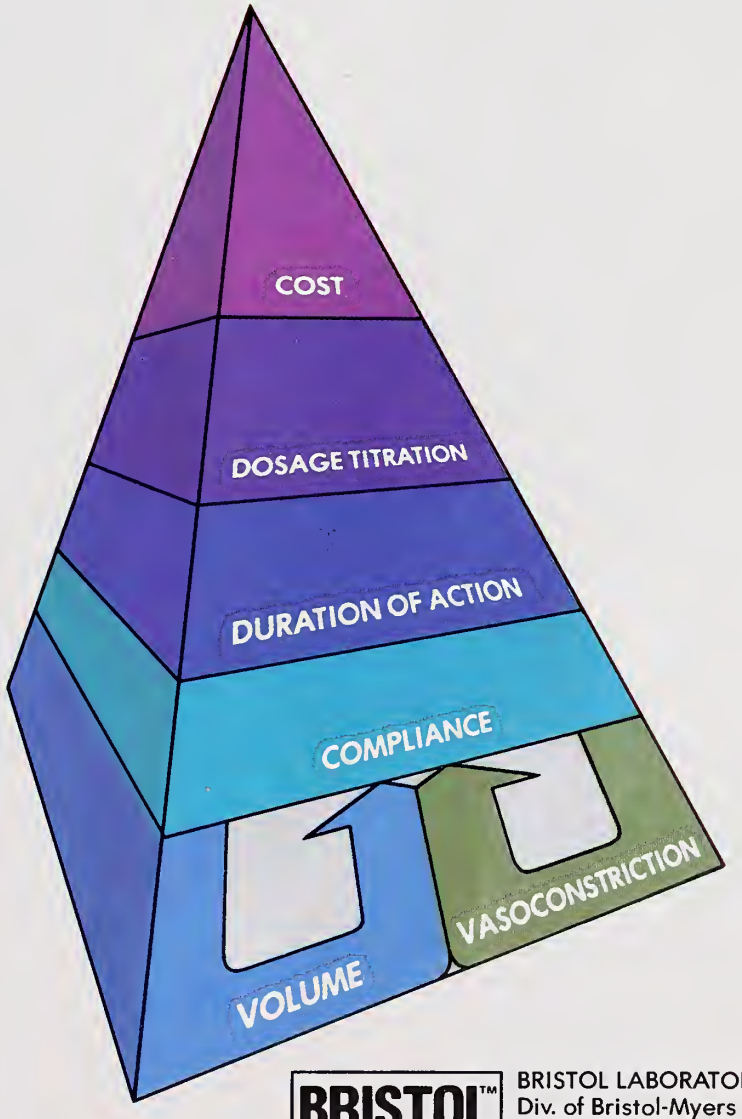
Salutensin contains Saluron (hydroflumethiazide), an intermediate-acting thiazide diuretic, which works over an 18–24 hour period, ideal for once-daily therapy.

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The total daily dose can be given once a day. Compared with multiple-daily-dosage medications, the chance of a missed dose is greatly reduced.

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At the foundation of "step two" hypertension therapy, control of both circulating volume and peripheral resistance can be effectively achieved with the combination tablet Salutensin one day at a time.



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References: 1. Finnerty, F. A. et al.: An Evaluation of Step 2 Regimens in Hypertension, data on file, Bristol Laboratories, 1977. 2. Red Book 1977.

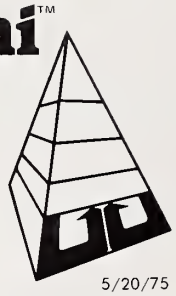
For a summary of prescribing information, please see following page.

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(hydroflumethiazide 25 mg./reserpine 0.125 mg.)

structured for the long run in "step two" hypertension



Saluron® (hydroflumethiazide)

5/20/75

For complete information consult Official Package Circular.

CONTRAINDICATIONS: Patients with anuria, oliguria, or hypersensitivity to this or other sulfonamide derived drugs.

WARNINGS: Saluron should be used with caution in severe renal disease. In patients with renal disease, thiazides may precipitate azotemia. Cumulative effects of the drug may develop in patients with impaired renal function.

Thiazides should be used with caution in patients with impaired hepatic function or progressive liver disease, since minor alterations of fluid and electrolyte balance may precipitate hepatic coma. Thiazides may be additive or potentiative of the action of other antihypertensive drugs. Potentiation occurs with ganglionic or peripheral adrenergic blocking drugs. Sensitivity reactions may occur in patients with a history of allergy or bronchial asthma.

The possibility of exacerbation or activation of systemic lupus erythematosus has been reported.

Usage in pregnancy: Usage of thiazides in women of childbearing age requires that the potential benefits of the drug be weighed against its possible hazards to the fetus. These hazards include fetal or neonatal jaundice, thrombocytopenia, and possibly other adverse reactions which have occurred in the adult.

Nursing mothers: Thiazides cross the placental barrier and appear in cord blood and breast milk.

PRECAUTIONS: Periodic determination of serum electrolytes to detect possible electrolyte imbalance should be performed at appropriate intervals.

All patients receiving thiazide therapy should be observed for clinical signs of fluid or electrolyte imbalance; namely, hyponatremia, hypochloremic alkalosis, and hypokalemia. Serum and urine electrolyte determinations are particularly important when the patient is vomiting excessively or receiving parenteral fluids. Medication such as digitalis may also influence serum electrolytes. Warning signs, irrespective of cause, are: Dryness of mouth, thirst, weakness, lethargy, drowsiness, restlessness, muscle pains or cramps, muscular fatigue, hypotension, oliguria, tachycardia, and gastrointestinal disturbances such as nausea and vomiting.

Hypokalemia may develop with thiazides as with any other potent diuretic, especially with brisk diuresis, when severe cirrhosis is present, or during concomitant use of corticosteroids or ACTH.

Interference with adequate oral electrolyte intake will also contribute to hypokalemia. Digitalis therapy may exaggerate metabolic effects of hypokalemia especially with reference to myocardial activity.

Any chloride deficit is generally mild and usually does not require specific treatment except under extraordinary circumstances (as in liver disease or renal disease). Dilutional hyponatremia may occur in edematous patients in hot weather; appropriate therapy is water restriction, rather than administration of salt except in rare instances when the hyponatremia is life threatening. In actual salt depletion, appropriate replacement is the therapy of choice.

Hyperuricemia may occur or frank gout may be precipitated in certain patients receiving thiazide therapy.

Insulin requirements in diabetic patients may be increased, decreased or unchanged. Latent diabetes mellitus may become manifested during thiazide administration.

Thiazide drugs may increase the responsiveness to tubocurarine.

The antihypertensive effects of the drug may be enhanced in the postsympathectomy patient.

Thiazides may decrease arterial responsiveness to norepinephrine. This diminution is not sufficient to preclude effectiveness of the pressor agent for therapeutic use.

If progressive renal impairment becomes evident, as indicated by a rising nonprotein nitrogen or blood urea nitrogen, a careful reappraisal of therapy is necessary with consideration given to withholding or discontinuing diuretic therapy.

Thiazides may decrease serum PBI levels without signs of thyroid disturbance.

ADVERSE REACTIONS:

A. Gastrointestinal system reactions: Anorexia, gastric irritation, nausea, vomiting, cramping, diarrhea, constipation, jaundice (intrahepatic cholestatic jaundice), pancreatitis.

B. Central nervous system reactions: Dizziness, vertigo, paresthesias, headache, xanthopsia.

C. Hematologic reactions: Leukopenia, agranulocytosis, thrombocytopenia, aplastic anemia.

D. Dermatologic-Hypersensitivity reactions: Purpura, photosensitivity, rash, urticaria, necrotizing angiitis (vasculitis) (cutaneous vasculitis).

E. Cardiovascular reaction: Orthostatic hypotension may occur and may be aggravated by alcohol, barbiturates, or narcotics.

F. Other: Hyperglycemia, glycosuria, hyperuricemia, muscle spasm, weakness, restlessness.

Whenever adverse reactions are moderate or severe, thiazide dosage should be reduced or therapy withdrawn.

USUAL DOSE: The average adult diuretic dose is 25 to 200 mg. per day. The average adult antihypertensive dose is 50 to 100 mg. per day. Therapy should be individualized according to patient response. This therapy should be titrated to gain maximal therapeutic response as well as the minimal dose possible to maintain that therapeutic response.

HOW SUPPLIED: Saluron (hydroflumethiazide 50 mg.): Bottles of 100.

Salutensin® • Salutensin-Demi™

(12) 10/27/78

(hydroflumethiazide, reserpine antihypertensive formulation)

For complete information consult Official Package Circular.

> **WARNING**
> This fixed combination drug is not indicated for initial therapy of hypertension. Hypertension requires therapy titrated to the individual patient. If the fixed combination represents the dosage so determined, its use may be more convenient in patient management. The treatment of hypertension is not static, but must be reevaluated as conditions in each patient warrant.

CONTRAINDICATIONS: Anuria, oliguria, active peptic ulceration, ulcerative colitis, severe depression or hypersensitivity to its components contraindicates the use of Salutensin.

WARNINGS: Small-bowel lesions (obstruction, hemorrhage, perforation and death) have occurred during therapy with enteric-coated formulations containing potassium, with or without thiazides. Such potassium formulations should be used with Salutensin only when indicated and should be discontinued immediately if abdominal pain, distention, nausea, vomiting or gastrointestinal bleeding occurs. Use cautiously, and only when deemed essential, in fertile, pregnant or lactating patients.

Use in pregnancy: Thiazides cross the placenta and can cause fetal or neonatal hyperbilirubinemia, thrombocytopenia, altered carbohydrate metabolism and possibly electrolyte disturbances. Fatal reactions may occur with reserpine during electroshock therapy; discontinue Salutensin 2 weeks before such therapy. Increased respiratory secretions, nasal congestion, cyanosis and anorexia may occur in infants born to reserpine-treated mothers.

PRECAUTIONS: Azotemia, hypochloremia, hyponatremia, hypochloremic alkalosis and hypokalemia (especially with hepatic cirrhosis and corticosteroid therapy) may occur, particularly with pre-existing vomiting and diarrhea. Potassium loss may cause digitalis intoxication. *Potassium loss responds to potassium-rich foods, potassium chloride or, if necessary, discontinuation of therapy.* Serum ammonia elevation may precipitate coma in precomatose hepatic cirrhotics. Discontinue therapy 2 weeks before surgery or if myocardial irritability, progressive azotemia or severe depression occur. Exercise caution in patients with chronic uremia, angina pectoris, coronary thrombosis or extensive cerebral vascular disease or bronchial asthma and in those with a history of peptic ulceration or bronchial asthma; in postsympathectomy patients; in patients on quinidine; and in patients with gallstones, in whom biliary colic may occur. Patients who have diabetes mellitus or who are suspected of being prediabetic should be kept under close observation if treated with this agent.

ADVERSE REACTIONS: Hydroflumethiazide: Skin-rashes (including exfoliative dermatitis), skin photosensitivity, urticaria, necrotizing angiitis, xanthopsia, granulocytopenia, aplastic anemia, orthostatic hypotension (potentiated with alcohol, barbiturates or narcotics), allergic glomerulonephritis, acute poncreatitis, liver involvement (intrahepatic cholestatic jaundice), purpura plus or minus thrombocytopenia, hyperuricemia, hyperglycemia, glycosuria, malaise, weakness, dizziness, fatigue, paresthesias, muscle cromps, skin rash, epigastric distress, vomiting, diarrhea and constipation. **Reserpine:** Depression, peptic ulceration, diarrhea, Parkinsonism, nasal stuffiness, dryness of the mouth, weight gain, impotence or decreased libido, conjunctival injection, dull sensorium, deafness, glaucoma, uveitis, optic atrophy, and, with overdosage, agitation, insomnia and nightmares.

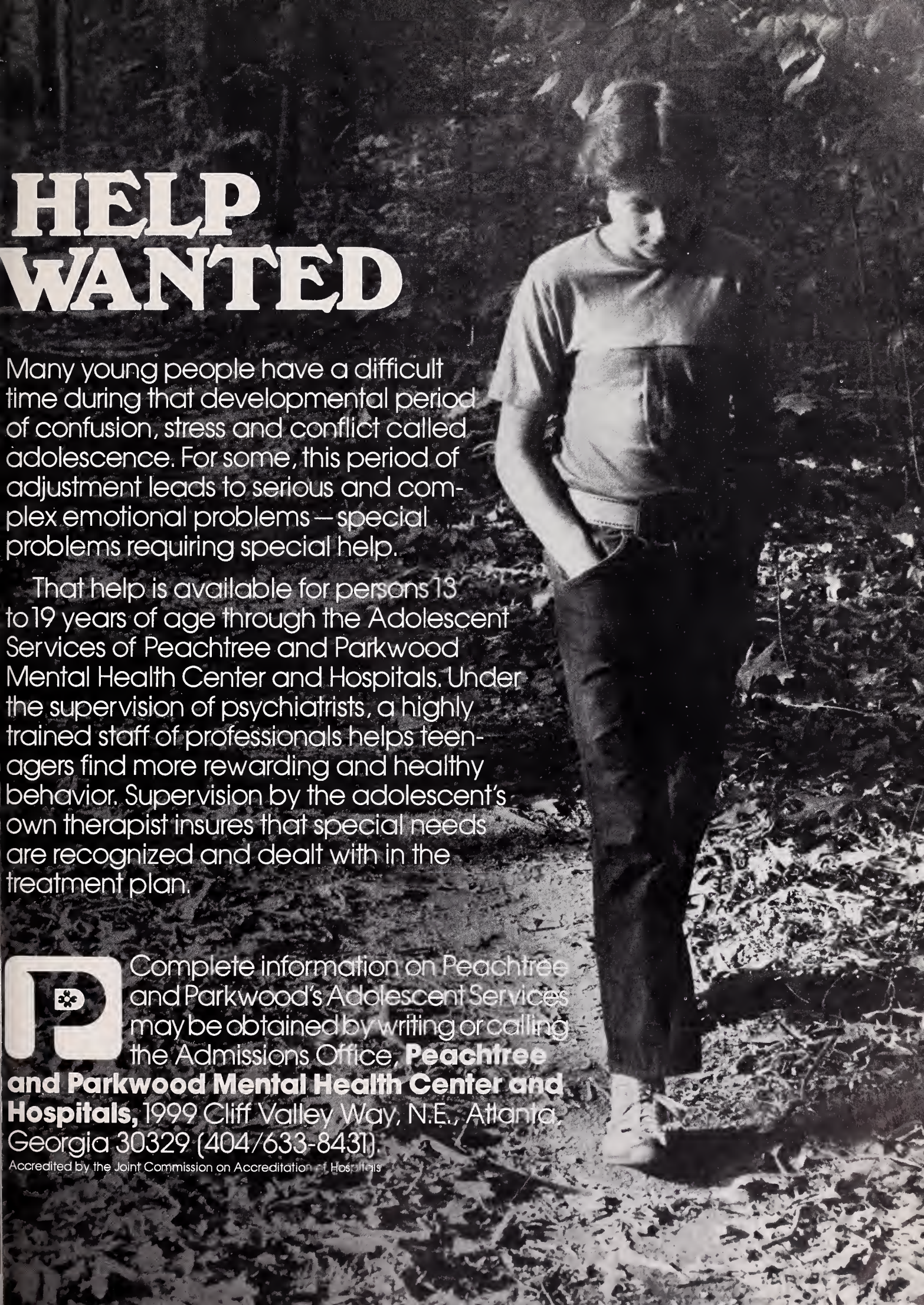
USUAL DOSE: 1 tablet b.i.d.

HOW SUPPLIED: Salutensin (hydroflumethiazide 50 mg., reserpine 0.125 mg.): Bottles of 100 and 1000.

Salutensin-Demi (hydroflumethiazide 25 mg., reserpine 0.125 mg.): Bottles of 100.

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Complete information on Peachtree and Parkwood's Adolescent Services may be obtained by writing or calling the Admissions Office, **Peachtree and Parkwood Mental Health Center and Hospitals,** 1999 Cliff Valley Way, N.E., Atlanta, Georgia 30329 (404/633-8431).

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editorial
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editorial

We Need Friends and a Better Understanding

THE CLAMOR GROWS ever louder, as the news media continues to emphasize our growing need for national health insurance (NHI). The latest Gallup Poll reveals that 53% of the public and 40% of the nation's physicians feel strongly that Americans need NHI. Moreover, 43% of the public supports NHI, even if it means an increase in taxes; this is in contrast to the supposed "Proposition 13 Mood." The Poll also shows that 66% felt costs were their most important problem in regard to health care. A majority of physicians believe that the quality of medical care will get worse with NHI, and 75% feel certain that with the NHI, the cost of medical care will rise faster than inflation. The incongruity of these polling results is remarkable.

Our organizational attempts to stem the tide of NHI do indeed seem meager, but consider the odds. Our greatest opponent is the Department of Health, Education, and Welfare (DHEW) with 1,125,000 employees, augmented by banks of computers, and funded with a budget of $182,000,000,000. In just 25 years, this servant of the public has accrued the third largest budget in the world, outranked only by the rest of the United States budget and the budget of the Soviet Union. Its daily spending of $500,000,000 roughly equals the spending of the combined 50 states. DHEW is truly a formidable opponent for those of us in the private practice of medicine.

Inflation, unemployment, low productivity, deficit trade balances, poor motivation, inability to compete for markets, bigger government, trends toward socialism — these are all afflicting us as the last bastion of the capitalistic free enterprise system. It seems unbelievable, and yet we have watched it happen before our very eyes. How has this happened? I believe that part of the reason is that we have not been effective enough in communicating our point of view to those in power and to the general public. Our basic economic education has been inadequate and is partially responsible for our ineffectiveness.

One effort to stem the bureaucratic tide and meet those educational needs has been spearheaded by the Chair of Private Enterprise at Georgia State University (GSU). First established in 1963 by concerned members of the Young Presidents Organization, a group of farsighted businessmen, there are now 27 similar chairs at other colleges and universities across the nation, with the avowed purpose of increasing understanding of private enterprise through the study of economics, history, management, and human behavior. We need to better understand these principles as well as each other and to seek means of working together.

On April 21, Dr. Michael Mescon, holder of the Chair of Private Enterprise at GSU, will speak at the Medical Association of Georgia's (MAG) Annual Session in Savannah, and discuss MAG's first "Private Enterprise Perspectives" (PEP) Seminar, to be held at the Colony Square Hotel in Atlanta on May 26 and 27.

All MAG members, Auxiliary members, house staff, and medical students are invited to attend this seminar to explore these topics:

—Who's Raising the Fuss and Why?
—The Market Place of Medicine
—The Nature of Regulation
—Economic Analysis of Medical Issues

—HMO — Medical Soviet or Social Good?
—The Supply and Distribution of Medical Services
—The Reimbursement Dilemma: The Case of Medicaid in Georgia
—The Medical Advertising Controversy
—Is There a Right to Health?

Giving the general presentations and conducting task force sessions will be GSU faculty members including Drs. Michael Mescon, Craig Aronoff, Bill Rushing, Roland Knobel, Max Holland, and Mark Schaefer.

We will certainly be stimulated and provoked, and probably jarred, and perhaps will come away with some new perspectives on how we relate to our private enterprise system and to the business world in general. In a final plenary session on Sunday, each task force will present conclusions and rationales; and from this, new directions for MAG may be derived.

The expanding role of government in economic life must be curtailed. Predictions of the economic future have always been a hazardous task, but our future is fairly obvious unless we seek to better understand our system and gather our allies to bolster our forces. Only then will we be able to effect a policy more favorable to the private practice of medicine.

"People are both the creators and the products of the organizations in which they live. As creators they have the power to influence the nature of these organizations — their structures, their activities, and values. To live creatively in them means to understand organizations and use that understanding to make them more effective."*

LaMar S. McGinnis, M.D.
Chairman, MAG Education Committee

* From the introduction to the pamphlet, "The Individual and the Future of Organizations," sponsored by the Franklin Foundation Lecture Series of the Chair of Private Enterprise.

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president's letter

These Are Good Times

PHYSICIANS ARE TODAY better educated, better trained, and more of an effective force in the world than ever before. Usually we do not appreciate good things or good times until they are past. Our school days, rearing our children, holidays, love affairs. These have a glow that is not only a penumbra lent by time. They are genuine. It is our perception that is at fault. Good times usually go unremarked, for good times seldom make headlines. I submit that it is restorative to our souls to say "I love you," here and now, and that we should appreciate the here and now. Let's do it.

With all of its warts, medicine is today reaping a splendid harvest of the efforts of good men and good luck, and the assiduous application of the scientific method over the years. These *are* good times, and we should appreciate them. The profession is respected. Laws have helped great numbers of patients avoid the sufferings of indigency. Technology and better communications and transportation have caused a change for the better in the whole medical picture.

That being said, we yet want to improve, and self-examination is the first step in doing so. Self-examination shows us that the median health of the nation now — in spite of all of the above — is not good. We know little of nutrition, and the fact is that the major diseases afflicting mankind today are nutrition-related. Our heredity, our environment, and our lifestyle all affect our health and longevity. We can do something about the lifestyle, but there is not the disposition as yet to do so.

Over 20 percent of the population is obese, indeed well over that amount. We know that this causes social problems, and that it shortens life spans. It spawns its own brand of misery. We know that atherosclerosis and its complications lead the parade in causing death and that nutrition is a big factor in causing this whole disease complex. We know that cancer seems to be linked to dietary practices. It is, therefore, remarkable that we physicians have shown so little interest in nutrition, and when such a therapeutic void exists, charlatans rush in. They have done so.

The subject of nutrition is generally recognized by the public as an important part of health care. Articles on nutrition appear each day in major newspapers. Books on the subject appear on the best-seller lists. Millions belong to organizations that promote weight reduction. Controversies rage on diet, fiber, refined sugar, natural foods, and the rest. Still the medical profession for the most part shows little interest.

"Nutritional experts" abound. They exert considerable influence on the populace. It is true and it is sad that those who would turn to their physicians for such advice find that that door is closed, for the doctor is not interested in prosaic problems. He is busy taking care of *sick* people; the lay public, in its anxiety to achieve and maintain good health will follow anyone who assumes a posture of authority. Some of these figures of authority are sincere and well-meaning, but rare is the lay person who knows what he is talking about. And do we try to correct this?

Nutrition education in this country hardly exists, and much of it that does exist is confused. This lack of interest and of adequate training — common to almost all of the medical specialties — causes loss of confidence by the patients, and it also causes poor care. The nutritional needs of women and of newborns, of adolescents and of the elderly, require special care. Total parenteral nutrition represents a major advance indeed, but how many of us know the principles on which their use is based? How many know which amino acids are essential or which vitamins or

minerals should be added and why? Perhaps most curious of all is the question of why the physician has this anti-nutrition bias.

We emphasize the curative aspects of patient care. Nutrition rarely cures patients, but it is an enormously important adjunct to other therapy. Apparently we tend to think that a subject not taught in medical schools cannot be important. *Most medical schools still do not teach a single required course in clinical nutrition.* The fault lies not only with practicing physicians but also with medical educators.

The problem of introducing nutrition into medical education is being wrestled with. There is so much groping. Because of increasing public concern of those among the profession and among the students who see the deficiency, efforts are being made to include nutrition in the standard curriculum. We should hope these efforts succeed. The proper use of nutritional knowledge should be a large part of a practitioner's armamentarium and of the entire medical discipline. Some day it will be.

Preventive medicine and the education of the general public regarding self-pollution with alcohol, drugs, tobacco, and improper foods can do much toward making these good times better times. It would eliminate many of the chronic illnesses now afflicting mankind. Without efforts, it will come. Better days are ahead.

Sincerely,

Carson B Burgstiner MD

Carson B. Burgstiner, M.D.
President, MAG

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legal page
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Liability of a Hospital for the Negligence of Its Staff Physicians

ROBERT N. BERG, *Atlanta**

If you have been a faithful reader of the Legal Page of the *Journal* for the past several years, you are probably familiar with the doctrine of *respondeat superior* — the legal theory by which employers are held responsible for the wrongful acts of their employees if the employees are acting within the scope of their employment. In addition, you are probably somewhat conversant in the area of the application of this doctrine with respect to the liability of a hospital for the negligent acts of its staff physicians.[1] Nevertheless, in light of the recent case of *Georgia Osteopathic Hospital, Inc., v. Hollingsworth,*[2] we thought it might be a good idea to review this topic and bring you up-to-date on the present law in Georgia.

Governing Legal Standards

In general, the application of the doctrine of *respondeat superior* to the relationship between a hospital and its staff physicians involves a determination of whether that relationship is one of employer-employee or employer-independent contractor. If the physician is found to be an independent contractor, the hospital will not be liable for the physician's negligence unless the hospital itself is found to be independently negligent in some other respect, such as in the selection of the physician. If, on the other hand, the physician is found to be an employee of the hospital, the hospital will be responsible for the physician's professional activities to the same extent as for nurses, orderlies, and other employees, and thus, the hospital will be liable for the negligent acts of the physician which are committed within the scope of employment.

In most cases, the Georgia courts have singled out one major factor as being dispositive in connection with the determination of the nature of the hospital-physician relationship. If the hospital has the right to control the time, manner, and method of treatment utilized by the physician, then the physician will be deemed to be an "employee" of the hospital. Conversely, if the hospital does not have the right to exercise such control, then the relationship between the hospital and the physician will be deemed to be that of employer-independent contractor rather than employer-employee.

Determining the Extent of Control

The determination of the extent to which the hospital has reserved the right to exercise control over the time, manner, and method of treatment provided by its staff physicians must necessarily focus on the working arrangement between the hospital and these physicians. In some cases, this working arrangement is evi-

* Prepared at the request of the Medical Association of Georgia. Mr. Berg is an associate in the firm of Powell, Goldstein, Frazer, & Murphy, General Counsel to the Association, 1100 C & S National Bank Building, Atlanta, Ga. 30303.

denced by a written contract which delineates the amount or lack of control held by the hospital over the physicians on its staff. In these cases, it may be possible for a court to determine as a matter of law that the relationship between the hospital and its staff physicians was that of employer-independent contractor, a determination which would both preclude the hospital from being held liable for the negligence of its staff physicians and also allow the hospital to avoid the time and expense involved in a jury trial.[3]

In other cases, the working arrangement between the hospital and its staff physicians is rather loosely structured, and the question of control is often neither discussed at the time the physicians begin work nor fully defined during the course of their relationship with the hospital. In these cases, it may be exceedingly difficult for a court to determine as a matter of law that the hospital did not reserve the right to exercise control over the treatment provided by its staff physicians. Thus, it will be up to the trier of fact to determine, after examining all of the facts, whether the relationship between the hospital and its staff physicians was one of employer-employee or employer-independent contractor.[4]

The recent *Hollingsworth* decision provides a good example of the legal analysis utilized by courts in Georgia in dealing with the second class of cases described above, those involving loosely structured arrangements between the hospital and its staff physicians. In *Hollingsworth,* the plaintiffs, a husband and wife, sought recovery from the hospital for allegedly negligent treatment provided by the attending physician in the hospital's emergency room. The physician, pursuant to an informal oral contract with the hospital, had been required to be on duty at the emergency room from 7:00 a.m. to 7:00 p.m., for which he was paid $100.00 a day in addition to any compensation he received from the patients he treated. The oral agreement also provided that the physician was responsible for contacting another staff physician to cover for him in the event that he was unable to be in the emergency room. Finally, although the oral agreement did not specify the procedures which the physician should use during the performance of his duties, it did require that he be in the emergency room at least once a month and that he perform his duties according to the existing professional standards.

The Georgia Court of Appeals, after examining the working arrangement between the hospital and the physician, held that it could not determine as a matter of law that the physician was an independent contractor, since there was a material question of fact as to whether or not the hospital had the right to exercise control over the time, manner, and method of treatment provided by the physician.[5] Thus, it was left up to the jury to determine, after examining all of the facts, whether or not such control existed.

Conclusion

It is fast becoming apparent in the developing case law in the area of a hospital's liability for the negligence of its staff physicians that in most cases the courts will not determine as a matter of law that the relationship between the hospital and its staff physicians is one of employer-independent contractor where the parties do not clearly define the terms of their relationship in a written agreement. Consequently, it is advisable for hospitals and their staff physicians to enter into written agreements setting out the nature of their relationship and determining, at that time, which party will bear the responsibility for the negligent treatment of patients. By doing so, it may be possible both to avoid costly and time-consuming factual inquiries into the nature of the relationship between the hospital and its staff physicians, and to minimize the risk that the trier of fact will make a determination that, contrary to the intent of the parties, the staff physicians are the employees of the hospital.

Notes

1. Previous articles on this topic which have appeared on the Legal Page of the *Journal* include: J. Winston Huff, "The Physician a Hospital Employee?" (August, 1974); and, Richard H. Vincent

and Charles Stodghill, "The Staff Physician's Negligence — When is the Hospital Liable?" (October, 1977).

2. ____ Ga. ____ (No. 33848, November 7, 1978), *aff'g* 145 Ga. App. 870 (1978).

3. See, *e.g., Pogue v. Hospital Authority of DeKalb County,* 120 Ga. App. 230, 170 S.E. 2d 53 (1969); *Overstreet v. Doctors Hospital,* 142 Ga. App. 895, 237 S.E. 2d 213 (1977).

4. See, *e.g., Hodges v. Doctors Hospital,* 141 Ga. App. 649, 234 S.E. 2d 116 (1977).

5. In order for the Court to determine as a matter of law that the hospital could not be held liable for the negligent acts of its staff physician, it is necessary that there be no genuine issue of material fact with respect to the hospital's relationship with the physician being one of employer-independent contractor. *Ga. Code Ann.* §81A-156.

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The Georgia Thoracic Society and the Georgia Lung Association are sponsoring the Fourth Annual Symposium on Lung Disease, June 17-21, 1979, at The Cloister on Sea Island, Georgia.

This postgraduate course will present workshops dealing with such topics as pulmonary thromboembolism, airflow obstruction, and bronchial asthma. In addition Sunrise Sessions conducted each morning will deal with oxygen therapy, mechanical ventilation, and office spirometry. This Symposium has been approved for Category I credit.

For further information, write to: Georgia Lung Association, 1383 Spring St., NW, Atlanta, GA 30309.

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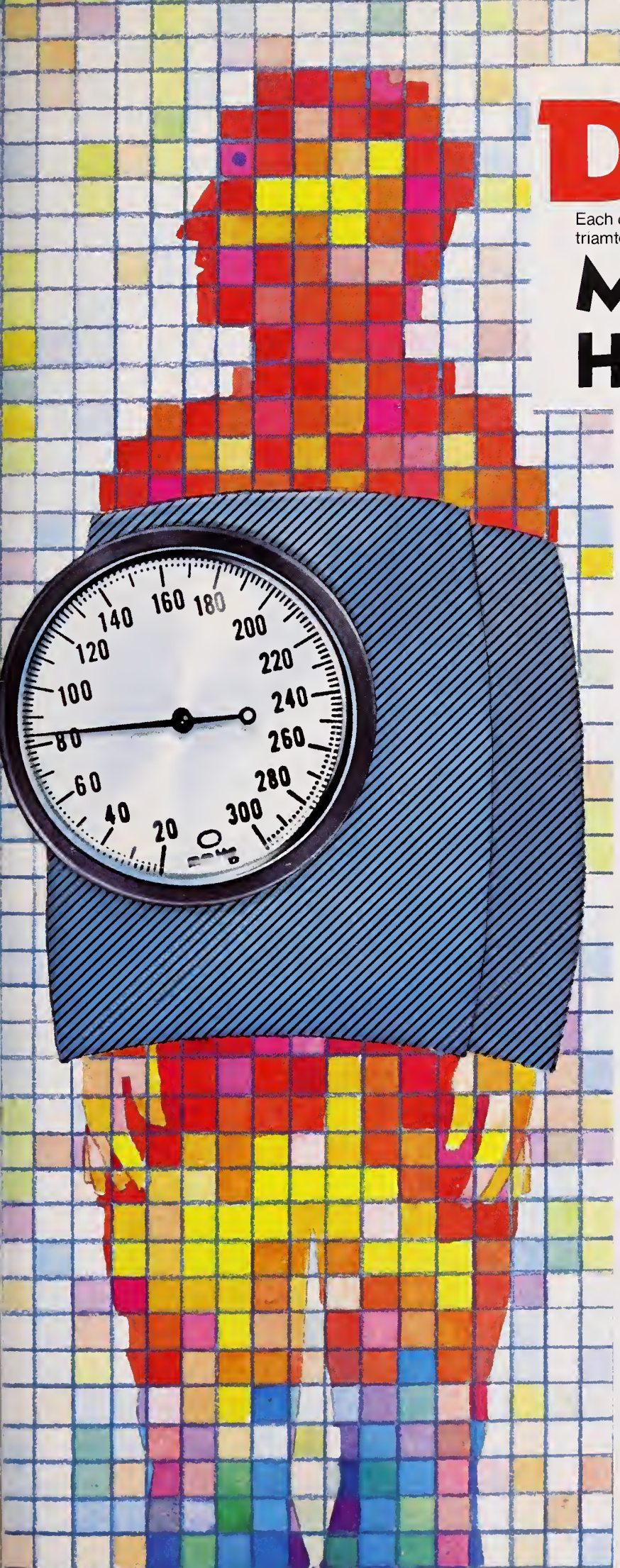
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* **Warning**
This drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual. If this combination represents the dosage so determined, its use may be more convenient in patient management. Treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

Contraindications: Further use in anuria, progressive renal or hepatic dysfunction, hyperkalemia. Pre-existing elevated serum potassium. Hypersensitivity to either component or other sulfonamide-derived drugs.

Warnings: Do not use potassium supplements, dietary or otherwise, unless hypokalemia develops or dietary intake of potassium is markedly impaired. If supplementary potassium is needed, potassium tablets should not be used. Hyperkalemia can occur, and has been associated with cardiac irregularities. It is more likely in the severely ill, with urine volume less than one liter/day, the elderly and diabetics with suspected or confirmed renal insufficiency. Periodically, serum K+ levels should be determined. If hyperkalemia develops, substitute a thiazide alone, restrict K+ intake. **Associated widened QRS complex or arrhythmia requires prompt additional therapy.** Thiazides cross the placental barrier and appear in cord blood. Use in pregnancy requires weighing anticipated benefits against possible hazards, including fetal or neonatal jaundice, thrombocytopenia, other adverse reactions seen in adults. Thiazides appear and triamterene may appear in breast milk. If their use is essential, the patient should stop nursing. Adequate information on use in children is not available.

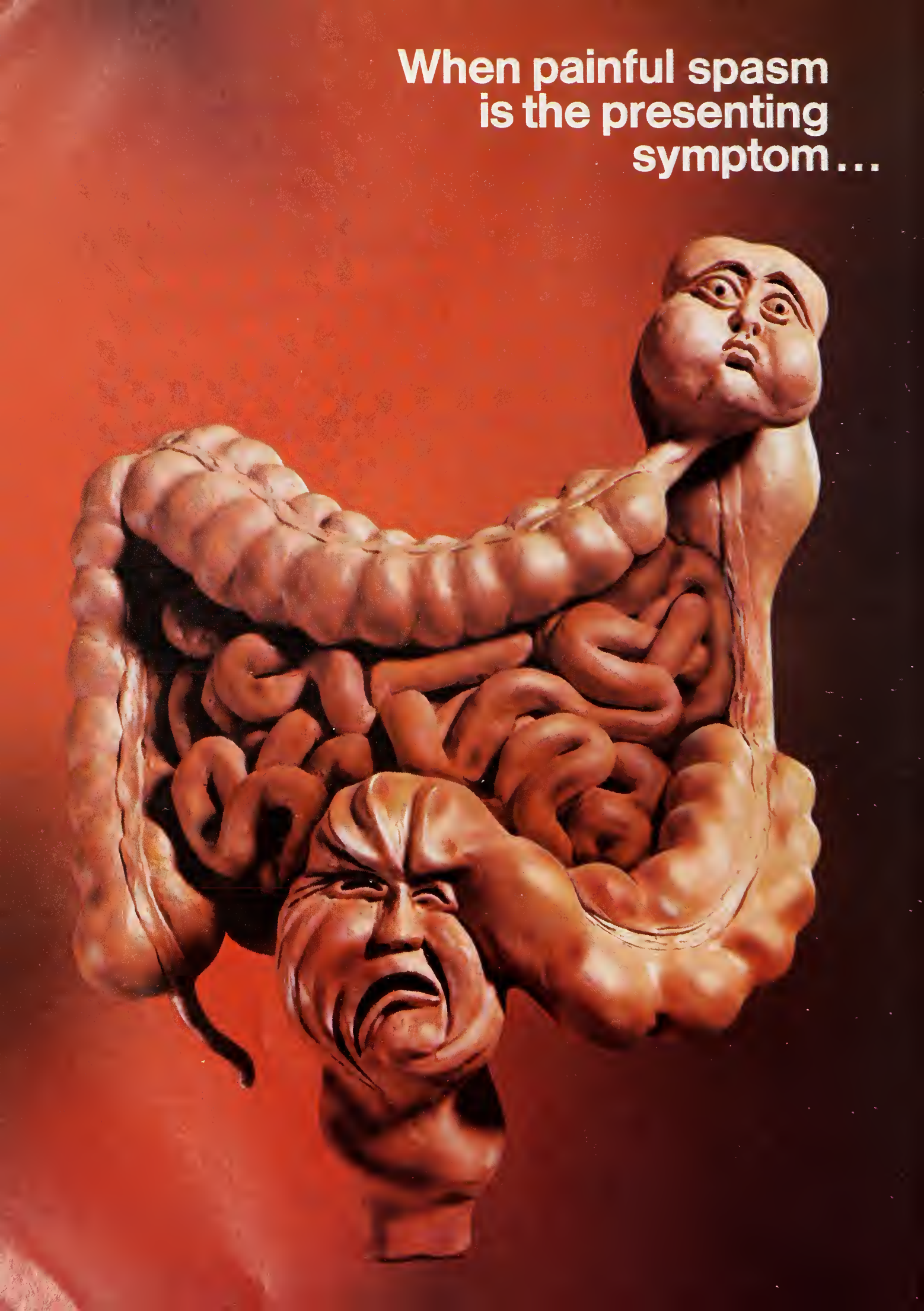
Precautions: Do periodic serum electrolyte determinations (particularly important in patients vomiting excessively or receiving parenteral fluids). Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics or those with suspected or confirmed renal insufficiency. Watch for signs of impending coma in severe liver disease. If spironolactone is used concomitantly, determine serum K+ frequently; both can cause K+ retention and elevated serum K+. Two deaths have been reported with such concomitant therapy (in one, recommended dosage was exceeded, in the other serum electrolytes were not properly monitored). Observe regularly for possible blood dyscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving triamterene, and leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with thiazides. Triamterene is a weak folic acid antagonist. Do periodic blood studies in cirrhotics with splenomegaly. Antihypertensive effect may be enhanced in post-sympathectomy patients. Use cautiously in surgical patients. The following may occur: transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), hyperuricemia and gout, digitalis intoxication (in hypokalemia), decreasing alkali reserve with possible metabolic acidosis. 'Dyazide' interferes with fluorescent measurement of quinidine.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth, anaphylaxis, rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting, diarrhea, constipation, other gastrointestinal disturbances. Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and, rarely, allergic pneumonitis have occurred with thiazides alone.

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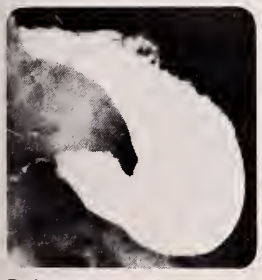
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*This drug has been classified "probably" effective in treating functional bowel/irritable bowel syndrome.

†See Warnings, Precautions and Adverse Reactions.

See following page for prescribing information.

Reference:
King, J.C. and Starkman, N.M.: Evaluation of an antispasmodic. Double-blind evaluation to control gastrointestinal spasms occurring during radiographic examination. A preliminary report. Western Med. 5:356-358, 1964.

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Brief Summary

INDICATIONS

Based on a review of this drug by the National Academy of Sciences–National Research Council and/or other information, FDA has classified the following indications as "probably" effective:

For the treatment of functional bowel/irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis.

THESE FUNCTIONAL DISDRDERS ARE OFTEN RELIEVED BY VARYING COMBINATIDNS DF SEDATIVE, REASSURANCE, PHYSICIAN INTEREST, AMELIORATION OF ENVIRONMENTAL FACTORS.

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Final classification of the less-than-effective indications requires further investigation.

CONTRAINDICATIDNS: Dbstructive uropathy (for example, bladder neck obstruction due to prostatic hypertrophy); obstructive disease of the gastrointestinal tract (as in achalasia, pyloroduodenal stenosis), paralytic ileus, intestinal atony of the elderly or debilitated patient; unstable cardiovascular status in acute hemorrhage; severe ulcerative colitis; toxic megacolon complicating ulcerative colitis; myasthenia gravis. WARNINGS: In the presence of a high environmental temperature, heat prostration can occur with drug use (fever and heat stroke due to decreased sweating). Diarrhea may be an early symptom of incomplete intestinal obstruction, especially in patients with ileostomy or colostomy. In this instance treatment with this drug would be inappropriate and possibly harmful. Bentyl may produce drowsiness or blurred vision. In this event, the patient should be warned not to engage in activities requiring mental alertness such as operating a motor vehicle or other machinery or perform hazardous work while taking this drug. PRECAUTIONS: Although studies have failed to demonstrate adverse effects of dicyclomine hydrochloride in glaucoma or in patients with prostatic hypertrophy, it should be prescribed with caution in patients known to have or suspected of having glaucoma or prostatic hypertrophy. Use with caution in patients with: Autonomic neuropathy. Hepatic or renal disease. Ulcerative colitis. Large doses may suppress intestinal motility to the point of producing a paralytic ileus and the use of this drug may precipitate or aggravate the serious complication of toxic megacolon. Hyperthyroidism, coronary heart disease, congestive heart failure, cardiac arrhythmias, and hypertension. Hiatal hernia associated with reflux esophagitis since anticholinergic drugs may aggravate this condition.

Do not rely on the use of the drug in the presence of complication of biliary tract disease. Investigate any tachycardia before giving anticholinergic (atropine-like) drugs since they may increase the heart rate. With overdosage, a curare-like action may occur. ADVERSE REACTIDNS: Anticholinergics/antispasmodics produce certain effects which may be physiologic or toxic depending upon the individual patient's response. The physician must delineate these. Adverse reactions may include xerostomia; urinary hesitancy and retention; blurred vision and tachycardia; palpitations; mydriasis; cycloplegia; increased ocular tension; loss of taste; headache; nervousness; drowsiness; weakness; dizziness; insomnia; nausea; vomiting; impotence; suppression of lactation; constipation; bloated feeling; severe allergic reaction or drug idiosyncrasies including anaphylaxis; urticaria and other dermal manifestations; some degree of mental confusion and/or excitement, especially in elderly persons; and decreased sweating. With the injectable form there may be a temporary sensation of lightheadedness and occasionally local irritation. DOSAGE AND ADMINISTRATION: Oosage must be adjusted to individual patient's needs.

Usual Dosage: Bentyl 10 mg. capsule and syrup: *Adults:* 1 or 2 capsules or teaspoonfuls syrup three or four times daily. *Children:* 1 capsule or teaspoonful syrup three or four times daily. *Infants:* ½ teaspoonful syrup three or four times daily. (May be diluted with equal volume of water.) Bentyl 20 mg.: *Adults:* 1 tablet three or four times daily. Bentyl Injection: *Adults:* 2 ml. (20 mg.) every four to six hours intramuscularly only. NOT FOR INTRAVENOUS USE. MANAGEMENT DF OVERDOSE: The signs and symptoms of overdose are headache, nausea, vomiting, blurred vision, dilated pupils, hot, dry skin, dizziness, dryness of the mouth, difficulty in swallowing, CNS stimulation. Treatment should consist of gastric lavage, emetics, and activated charcoal. Barbiturates may be used either orally or intramuscularly for sedation but they should not be used if Bentyl with Phenobarbital has been ingested. If indicated, parenteral cholinergic agents such as Urecholine® (bethanecol chloride USP) should be used.

Product Information as of October, 1978.

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A Report from the Georgia Cancer Management Network on: Shoulder Function After Mastectomy

ROBERT H. JOHNSON JR., M.D., *Augusta**

Introduction

THE GEORGIA CANCER MANAGEMENT NETWORK is comprised of cancer-oriented physicians and nurses in 12 area cancer facilities located in eight cities — Atlanta, Augusta, Decatur, LaGrange, Rome, Columbus, Savannah, and Albany (JMAG 66:12, 1977). Since its inception 3 years ago, the Network has been collecting data on female patients with breast cancer and suggesting reasonable guidelines for management. Patients have been followed closely under the supervision of a facility medical director and a breast cancer nurse-coordinator. In addition to such usual information as stage of disease, treatment choice, and survival, many other parameters, such as impairment of self care, social activity, and earning capacity, are recorded on each patient and stored in our computer. Some of this data, while still preliminary, is sufficiently available for the interest and use of Georgia physicians. We intend to occasionally publish some of this data on the "Cancer Page." The importance of such data is that it is generated here in Georgia by Georgia physicians caring for Georgia patients and thus should be an accurate reflection of our own successes, failures, problems, and needs and *not* those of some prestigious yet far away cancer center.

The report presented here deals with shoulder function after modified and radical mastectomy, a parameter which is measured periodically by the nurse-coordinators.

Table 1 shows the relationship between the type of mastectomy surgery performed on 717 patients and subsequent shoulder function as evaluated 1 year after surgery. Although the number of patients in each category is small and the vagaries of breast cancer are many, it is still apparent that the less radical operation does not necessarily confer greater shoulder function to the patient, a finding which is contrary to expectation. One possible explanation for this is that there is interference with the innervation and/or blood supply to the pectoralis major muscle when it is preserved in modified radical mastectomy. This may result in atrophy and fibrosis, thus binding the shoulder and causing decreased mobility as compared with radical mastectomy. Or, it may be that when the modified radical operation is performed the surgeon does not emphasize the importance of shoulder physiotherapy as much as he would had the radical operation been done. Surgeons

* Dr. Johnson is the Facility Director of the Eugene Talmadge Memorial Hospital, Georgia Cancer Management Network and Professor of Surgery, Medical College of Georgia. His address is Medical College of Georgia, Augusta, GA. 30309. Prepared at the request of the Georgia Division, American Cancer Society. Others wishing to contribute papers to this page are invited to send them to David B. Roberts, M.D., 2400 13th St., Columbus, Ga. 31906.

TABLE 1

RELATIONSHIP BETWEEN TYPE OF SURGERY AND SHOULDER FUNCTION IN 717 MASTECTOMY PATIENTS EVALUATED 1 YEAR AFTER SURGERY BY THE GEORGIA CANCER MANAGEMENT NETWORK

Stages 0, I, II (TMN pathologic staging)

	Radical Mastectomy (356 patients)	Modified Radical Mastectomy (361 patients)
Normal (161-180°)		
abduction	87.4%	84.8%
flexion	88.5%	86.2%
Slightly Impaired (136-160°)		
abduction	8.7%	7.2%
flexion	8.1%	5.8%
Moderately Impaired (91-135°)		
abduction	1.4%	3.3%
flexion	0.8%	1.7%
Markedly Impaired (0-90°)		
abduction	2.5%	4.7%
flexion	2.5%	6.3%
Swelling of arm	13.2%	7.9%

should be alert to this possibility. These findings certainly do not preclude the modified surgical approach, since there is appreciably less swelling of the arm with this procedure. Surgeons should nevertheless consider these findings when deciding which procedure to use.

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The M-Mode Echocardiogram and Endocarditis

STEPHEN D. CLEMENTS JR, M.D., and JOHN V. PERKINS, *Atlanta**

ENDOCARDITIS REMAINS a hazardous problem in medicine. Despite special techniques and potent antibiotics, diagnosis and therapy are not always straightforward. Valve ring abscesses still occasionally occur, and valve replacement is commonly required. Antibiotic-resistant bacteria and fungus infections pose serious problems often involving high mortality rates. All of these difficulties suggest the need for the earliest possible diagnosis and for prompt, effective therapy.

There has been considerable interest in the past several years in the M-mode echocardiogram for the diagnosis and assessment of endocarditis. As our knowledge increases in this area, the M-mode echocardiogram is becoming more important. The following points deserve special emphasis:

(1) The absence of demonstrable valvular vegetations on echocardiogram does not rule out either endocarditis or valve ring abscess.
(2) Vegetations on echocardiogram are commonly associated with a degree of valve impairment that may later require surgery.
(3) Vegetations as small as 3mm in diameter may be detected, but larger vegetations may be missed if conditions are not appropriate.[1]
(4) Huge, bulky vegetations suggest fungal endocarditis.[2]
(5) Healed and infected vegetations may have a similar appearance on the echocardiogram.
(6) Flail aortic and mitral leaflets, although commonly associated with endocarditis, may produce an echocardiographic picture similar to vegetations, yet the "fuzzy" echos may be fine vibrations of a portion of the flail leaflet without infection.[3]
(7) In cases of drug addiction and "mainline" injections, echocardiography may detect vegetations on the tricuspid valve in the absence of murmur of tricuspid regurgitation.

It should be emphasized that when fever and murmur are present, with or without positive blood cultures, endocarditis should be suspected and treated accordingly. As noted above, a negative echocardiographic study for vegetations does not exclude endocarditis, and a positive study is a serious finding and sets the stage for embolization and the possible need for valve replacement. Smaller vegetations have certainly been observed to heal and completely disappear on echocardiogram. Involved valves should be avoided at catheterization, since vegetations can be dislodged by the catheters.

Aortic valve vegetations produce "fuzzy" echos on the valve leaflets that may

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Articles for this page are prepared at the request of the Physician Education Committee of the Georgia Heart Association, Broadview Plaza, Level C, 2581 Piedmont Rd., NE, Atlanta, Ga. 30324.

move with the valve leaflets from systole to diastole. The vegetations that have attachments to the more basal portions of the valve produce echos that appear continuous with the aortic wall and may suggest thickening of the wall. Occasionally, a sizeable vegetation attached to the ventricular surface of the aortic valve will prolapse into the left ventricular outflow tract in diastole and approach the anterior mitral leaflet, mimicking mitral vegetations (Figure 1).

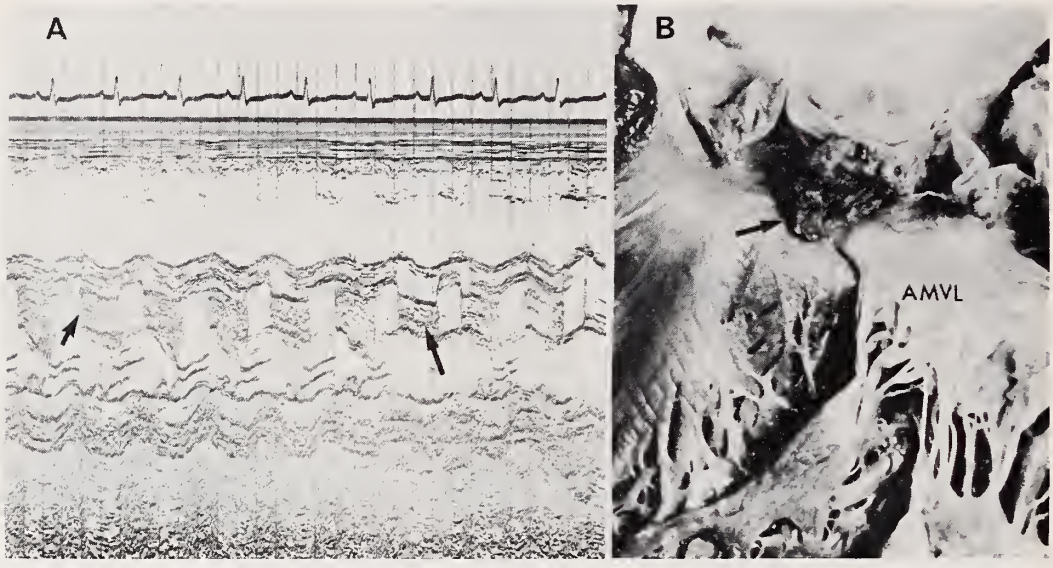


Figure 1. A. Echocardiogram sweeping from left ventricle to aorta, demonstrating aortic vegetations with a "fuzzy" appearance in the area of the non-coronary cusp (long arrow) and prolapsing into the outflow tract in diastole (short arrow). B. Pathology specimen from the patient whose echocardiogram is illustrated in A, demonstrating the large vegetation attached to the ventricular surface of the non-coronary cusp. One can see how this vegetation would prolapse into the left ventricular outflow tract and come into contact with the anterior mitral valve leaflet (AMVL).

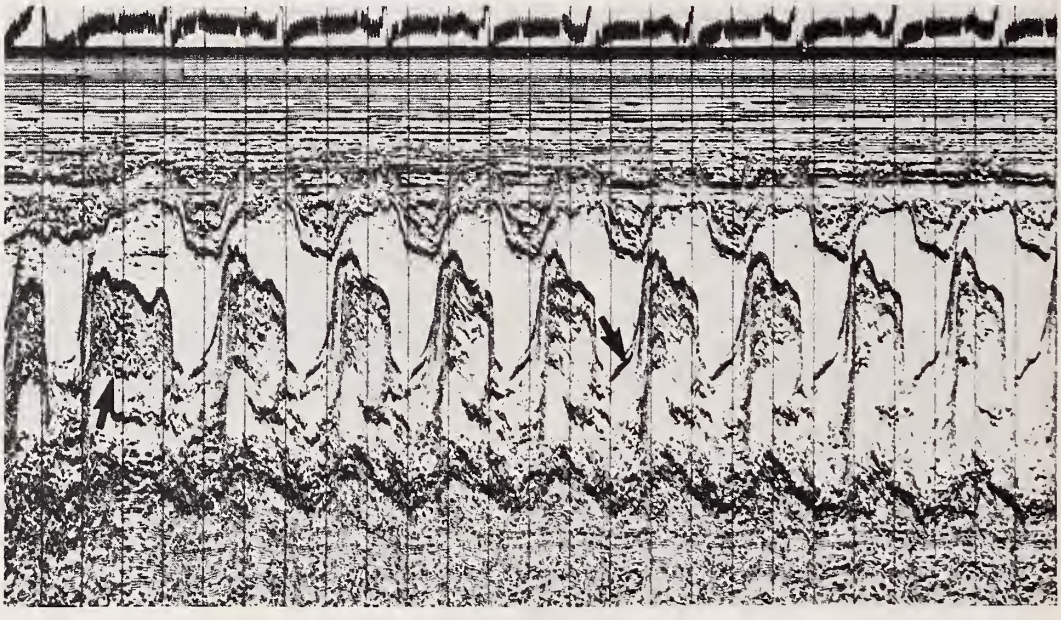


Figure 2. Fungal endocarditis (candida), producing a large vegetation attached to the anterior mitral valve leaflet. Left arrow shows vegetation behind the leading edge of the anterior mitral valve leaflet in diastole. Right arrow points to the clear zone behind the leading edge of the anterior mitral leaflet as seen with prolapsing myxoma, suggesting that the vegetation is attached to the atrial surface of the valve at its base and prolapses through the mitral orifice in diastole following the valve leaflet by a brief interval.

Mitral vegetations and tricuspid vegetations are usually located in the atrial surface of the valve and produce "fuzzy" echos that move with the mitral leaflet, giving it a thickened appearance. Either anterior or posterior mitral leaflets or both may have vegetations. Large vegetations look somewhat like atrial myxoma (Figure 2).

In cases of altered immune response, fungal endocarditis may occur. These

vegetations commonly embolize, are large and bulky, and require prompt surgery if the clinical situation will permit (Figure 2).

Flail leaflets may follow endocarditis and are easily diagnosed by echocardiogram. Small portions of either the aortic or mitral valve may vibrate in systole or diastole, producing a picture similar to endocarditis with vegetations. Increasing the paper speed on the echocardiographic recorder and correlating this with phonocardiogram demonstrate that similar vibratory frequencies are present in both and suggest a vibratory structure rather than a "fuzzy" echo from a vegetation (Figure 3). Cross sectional echocardiographic techniques may add more to the diagnostic accuracy of M-mode techniques, but experience in this area is still limited.

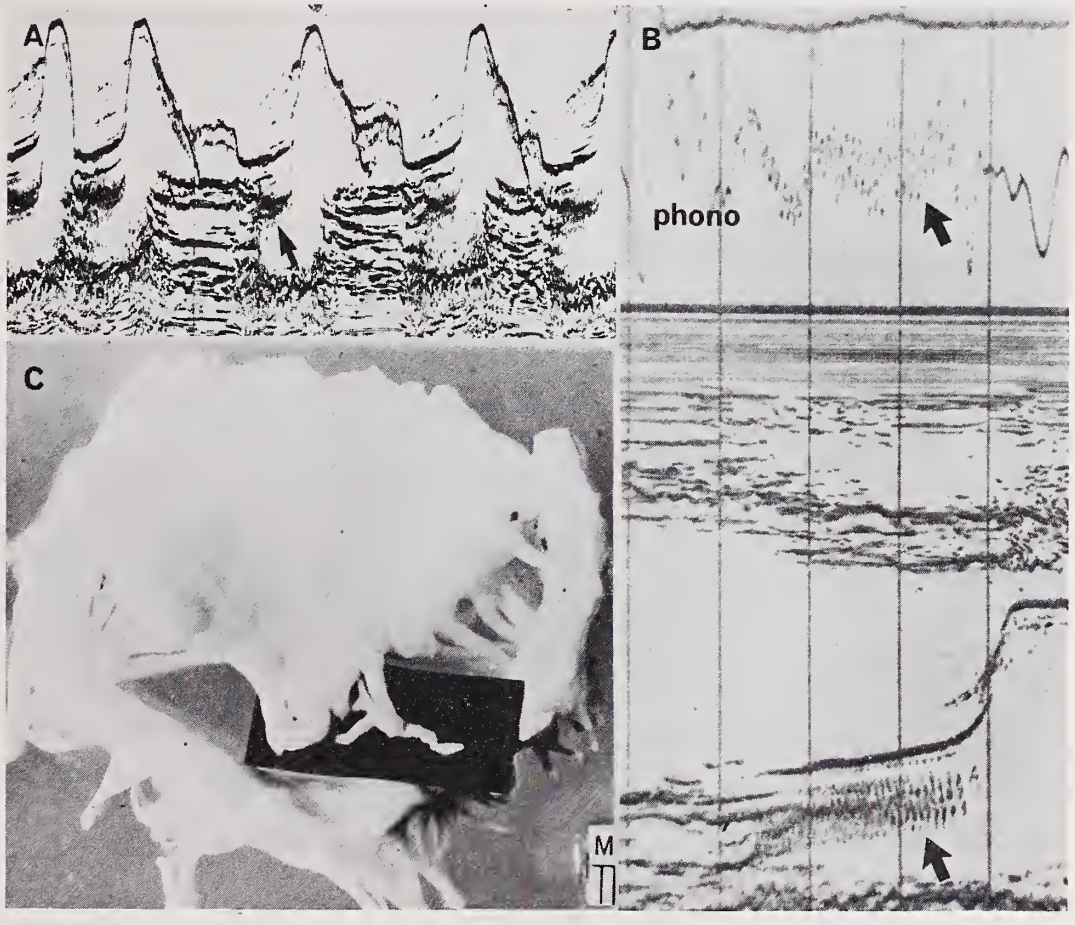


Figure 3. A. Echocardiogram at left ventricular-left atrial junction, demonstrating what appears to be "fuzzy" echos on the mitral leaflets in systole (arrow). B. Simultaneous echocardiogram-phonocardiogram (phono) showing systolic vibrations of mitral leaflets (bottom arrow) that have a frequency of vibration similar to those in the apical systolic murmur recorded on the phonocardiogram (top arrow). C. Surgical specimen (mitral valve) with small black tag placed under tip of anterior mitral valve leaflet where attached chordae tendineae were ruptured. All chordae attached to this tip were ruptured. The murmur had a "honking" quality.

Summary

The M-mode echocardiogram is helpful in the diagnosis of bacterial and fungal endocarditis. The absence of echo findings, however, does not exclude this disease. A positive echocardiogram for vegetations either on mitral, aortic, or tricuspid valves is a serious finding and may signal that severe hemodynamic problems are ahead.

References

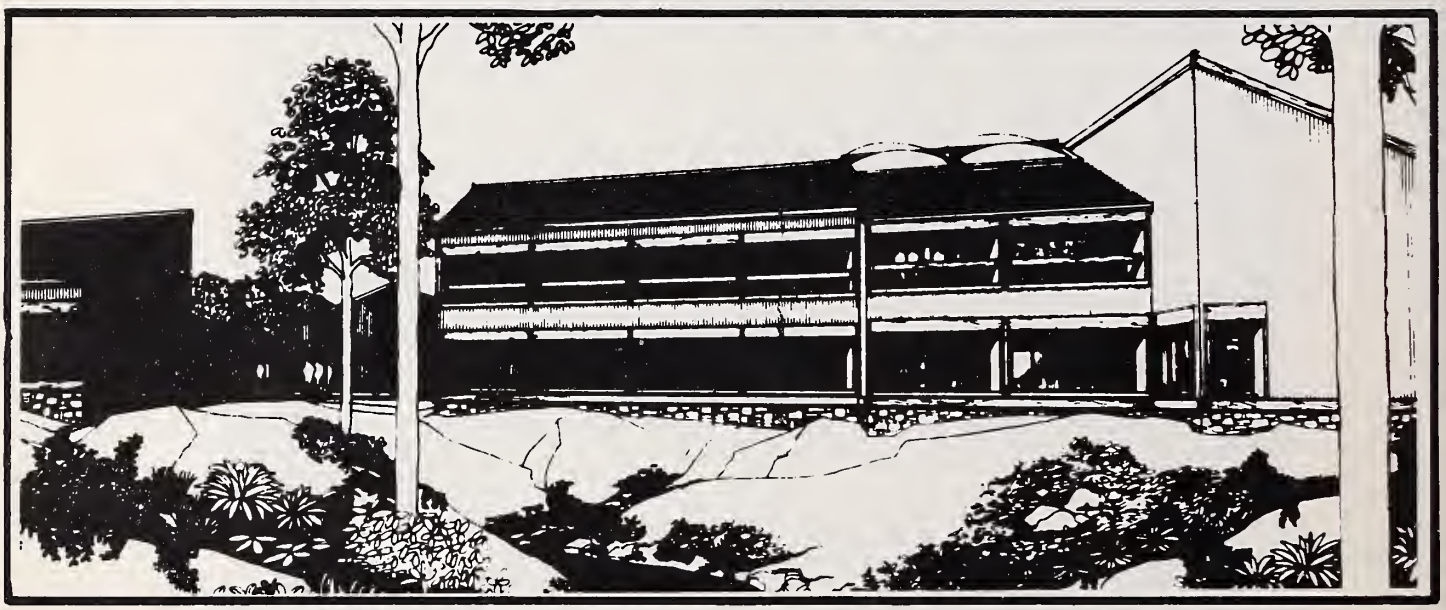
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CONTRAINDICATIONS: In patients with myasthenia gravis and where a hypersensitivity to procainamide exists; bear in mind cross sensitivity to procaine and related drugs. Should not be given to patients with complete atrioventricular heart block. Contraindicated in cases of second degree and third degree A-V block unless an electrical pacemaker is operative.

PRECAUTIONS: Evidence of untoward myocardial responses should be carefully watched for in all patients. In the presence of myocardial damage with atrial fibrillation or flutter, the ventricular rate may increase suddenly as the atrial rate is slowed; adequate digitalization reduces but does not abolish this danger. Ventricular tachysystole is particularly hazardous if myocardial damage exists.

The dislodgment of mural thrombi producing an embolic episode may occur in correcting atrial fibrillation due to the forceful contractions of the atrium.

Extreme caution is required in attempting to adjust the heart rate when ventricular tachycardia has occurred during an occlusive coronary episode or where the use of procainamide may result in additional depression of conduction and ventricular asystole or fibrillation as in second degree and third degree A-V block, bundle branch block, or severe digitalis intoxication.

Bear in mind when treating ventricular arrhythmias in patients with severe organic heart disease and ventricular tachycardia that complete heart block, which may be difficult to diagnose, may be present. Since asystole may result if the ventricular rate is significantly slowed without attainment of regular atrioventricular conduction, procainamide should be stopped and the patient re-evaluated.

In the presence of both liver and kidney damage, normal dosage may produce symptoms of overdosage—principally ventricular tachycardia and severe hypotension.

A syndrome resembling lupus erythematosus has been reported with oral maintenance procainamide therapy. Common symptoms are polyarthralgia, arthritis and pleuritic pain. Fever, myalgia, skin lesions, pleural effusion and pericarditis may also occur. Rare cases of thrombocytopenia or Coombs-positive hemolytic anemia, possibly related to this syndrome, have been reported. Measure anti-nuclear antibody titers at regular intervals in patients on procainamide for extended periods of time or in whom symptoms suggestive of lupus-like reaction appear; in event of rising titer (anti-nuclear antibody) or clinical symptoms of LE, assess the benefit/risk ratio related to continued procainamide therapy (see boxed Warning). Steroid therapy may be effective if discontinuation of procainamide does not cause remission of symptoms. If the syndrome develops in a patient with recurrent life-threatening arrhythmias not otherwise controllable, steroid-suppressive therapy may be used concomitantly with procainamide.

ADVERSE REACTIONS: Hypotension is rare with oral administration. Serious disturbances of cardiac rhythm such as ventricular asystole or fibrillation are more common with I.V. administration.

Large oral doses may sometimes produce anorexia, nausea, urticaria, and/or pruritus.

A syndrome resembling lupus erythematosus has been reported in patients on oral maintenance therapy (see Precautions). Reactions consisting of fever and chills have been reported, including a case with nausea, vomiting, abdominal pain, acute hepatomegaly, and a rise in serum glutamic oxaloacetic transaminase following single doses of the drug. Agranulocytosis has been occasionally reported following repeated use of the drug, and deaths have occurred. Therefore, routine blood counts are advisable during maintenance procainamide therapy; and the patient should be instructed to report any soreness of the mouth, throat or gums, unexplained fever or any symptoms of upper respiratory tract infection. If any of these symptoms should occur and leukocyte counts indicate cellular depression, procainamide therapy should be discontinued and appropriate treatment should be instituted immediately. Bitter taste, diarrhea, weakness, mental depression, giddiness, psychosis with hallucinations, and hypersensitivity reactions such as angioneurotic edema and maculopapular rash have been reported.

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PERSONALS

First District

Savannah physician, **James C. Metts Jr., M.D.,** has been elected to the Board of Trustees of the Georgia Infirmary Non-Profit House, Inc. during the 146th annual meeting of the board.

James Roshto, M.D., a Statesboro physician, has fulfilled all requirements for board certification in obstetrics and gynecology.

Third District

Joseph T. Christmas, M.D., Vienna, has been recertified as a Diplomate of the American Board of Family Practice.

Jim Dudley, M.D., of Americus, spoke on "Progress in Medicine" at a meeting of the Americus Rotary Club at the Country Club.

Vienna physician **Robert C. Garrett, M.D.,** has been named a Diplomate of the American Board of Family Practice.

Fourth District

John F. O'Brien, M.D., of Decatur, was recently appointed to the faculty of Emory University School of Medicine, Department of Dermatology. He has taken over the practice of H. Jordan Whyte, M.D., in Decatur, who returned to New Zealand.

Decatur obstetrician and gynecologist, **Theodore G. Smith, M.D.,** has opened a second office in Conyers.

At the 1979 Annual Meeting of the DeKalb Medical Society Mr. Pat Patterson, Senior Vice-President for Decatur Federal Savings and Loan, presented the 1978 Julius McCurdy Citizenship Award to **Luther Vinton, M.D.,** of Avondale Estates.

Fifth District

Dave M. Davis, M.D., Director of Psychiatric Services at Peachtree and Parkwood Mental Health Center and Hospital in Atlanta, is one of 12 psychiatrists from the United States and Canada to become a certified Diplomate in forensic psychiatry.

William A. Mason, M.D., Atlanta physician and health educator, is the recipient of the 1978 Aven Cup, an award of the Medical Association of Atlanta for outstanding community service by a member of the medical profession.

Sixth District

Paul Raymond Phelps, M.D., of Macon, has been named "Doctor of the Year" by the Macon Chapter of the American Association of Medical Assistants and the Medical Service Representatives.

A. D. Duggan, M.D., of Washington, has been appointed Clinical Instructor, Department of Family Practice in the Medical College of Georgia School of Medicine.

Carroll Beasley, M.D., Marietta, **Hubert Greenway, M.D.,** Marietta, and **Rosa C. Urrutia, M.D.,** Smyrna, have been certified as Diplomates of the American Board of Family Practice.

Jerald Sherman, M.D., Marietta, has been board certified in obstetrics-gynecology.

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Eighth District

Robert W. Smith III, M.D., an Atlanta rheumatologist, **Joseph E. Brown, M.D.,** and **Don Roberts, M.D.,** Brunswick orthopedic surgeons, participated in a forum on arthritis sponsored by Brunswick Junior College, the Pilot Club of Brunswick, and the Arthritis Foundation.

Ninth District

Paul D. Webster III, M.D., chairman of the Department of Medicine at the Medical College of Georgia and Associate Chief-of-Staff for Research at the VA Medical Center in Augusta, has been chosen president-elect of the Southern Society for Clinical Investigation.

Tenth District

Augusta physician, **Edwin Bronstein, M.D.,** has recently been elected chairman of the Committee on Maternal Health of the Georgia State Obstetrics and Gynecology Society. Dr. Bronstein is a professor of obstetrics and gynecology and is chief of maternal health and family planning at the Medical College of Georgia.

Margaret B. DeVore, M.D., of Augusta, has been named Associate Dean for Students in the School of Medicine at the Medical College of Georgia.

Walter Jagiella, M.D., has relocated his practice from Atlanta to Wilkes County. Dr. Jagiella will occupy the clinic formerly operated by Dan Duggan, M.D.

SOCIETIES

At their February meeting, the **Bibb County Society** members heard George B. Rankin, M.D., of the Cleveland Clinic in Ohio. He spoke on cancer surveillance in ulcer colitis, the use of immunosuppressive treatments, and the results of the National Cooperative Crohn's Disease Study.

The Cobb County Chamber of Commerce presented a program to the **Cobb County Medical Society** at its March meeting. The program was entitled "The Affect of the Medical Society in the Cobb County Business Community."

Mr. Gilbert R. Campbell Jr., Executive Vice-President of the DeKalb Chamber of Commerce spoke to the members of the **DeKalb County Medical Society** at their February meeting.



No man is more worthy of esteem than a physician who, having studied nature from his youth, knows the properties of the human body, the diseases which assail it, and the remedies which will benefit it, who exercises his art with caution, and who gives equal attention to the rich and the poor.
Voltaire: *Philosophical Dictionary,* 1764

Physician's Recognition Award Recipients

LISTED BELOW *are those physicians in Georgia who have earned the AMA's Physician's Recognition Award from October through December 1978.*

The award was established in 1969 "to recognize, encourage and support physicians who participate regularly in continuing medical education and to emphasize the importance of developing more meaningful continuing medical education opportunities for physicians." A minimum of 150 credit hours of CME must be earned over a three-year period to qualify for the award. The hours may include such activities as conferences, residencies, teaching, writing, private reading, listening to cassettes, home study courses, consultation, and peer review; at least 60 of the hours, however, must be from formal CME programs sponsored or co-sponsored by organizations accredited for these activities.

We congratulate the following physicians who have distinguished themselves and their profession by their commitment to continuing education:

Gabriel Miguel Alfonso, Milledgeville
Jose Fernando Angel, Savannah
Mohammad Arshad, Atlanta
Richard Albert Bagby, Atlanta
John Jay Baker, Atlanta
Jose Luis Balbona, Atlanta
William Henry Biggers, Atlanta
Bruce Ira Bodner, Atlanta
Charles Emory Bohler, Brooklet
J. Gordon Brackett, Atlanta
Harold Joseph Brody, Atlanta
Mark Brown, Augusta
Rodney Mack Browne, Macon
Milton Daniel Byrd, Atlanta
Thomas Roche Cadier, Dunwoody
Diana Deane Carr, Augusta
Augustin S. Carswell, Augusta
Charles Richard Chamberlain, Augusta
Louis G. Chelton, Atlanta
Soong Pyo Chung, Dublin
Henry Tucker Clay, Macon
Fred Jessup Coleman, Dublin
Ronald Nevis Cook, Atlanta
Mark John Costantino, Athens
Robert Cowgill, Atlanta
Thomas Joseph Croft, East Point
Joseph Samuel Cruise, Atlanta
Jose Ramon Del Cueto, East Point
Eugene David Davidson, Atlanta
Nicholas E. Davies, Atlanta
Alexis Hal Davison, Atlanta
Norberto G. De Guzman, Atlanta
Keith Allen Dimond, Savannah
Gerald Domescik, Atlanta
Asa D. Duggan, Washington
Ahmed Sabri R. Elguindi, Martinez
John Jay Elms, Augusta
Frederick C. Ferguson, Augusta
Edwin E. Flournoy, Albany
Henry Jack Ford, Athens
Paul David Forney, Augusta
William T. Freeman, Augusta
Daniel Logan French, Fort Benning
John Henry Geckler, Atlanta
John Abner Goldman, Atlanta
James N. Gordon, Atlanta
Richard S. Graft, Savannah
John Michael Griffin, Atlanta
Mary Anne Tyler Hagler, Augusta
Michael B. Hanna, Newnan
Emory W. Holloway, Macon
Richard Powell Holm, Atlanta
Kenneth W. Horne, Athens
John Clifford House, Winder
Julian Clyde Hutchins, Valdosta
Peter Hydrick, East Point
Charles Joel, Decatur
C. F. Johnson, Augusta
Henry C. Johnson, Atlanta
Ray Loring Johnson, Atlanta
A. Paul Keller, Athens
Thomas Nelson Kias, Athens
Garland Eugene Kinard, Rossville
Gilbert John Kloster, Atlanta
William Cottrell Lang, Atlanta
Everett Martin Lee, Atlanta
Lawrence Kendrick Lewis, Madison
Der-Gen Lin, Dublin
Jay Ira Lipoff, Augusta
Paul E. Longaker, Macon
Eugene Michael Louviere, Fort Stewart
William Graham Love, Columbus
Victor King-Shing Lui, Atlanta
Charles Roberts Lull, Dalton
Stanislaw Martynski, Fort Oglethorpe
Earl T. McGhee, Dalton
Alice Olivia McMichael, Augusta
Joseph Mendeloff, Atlanta
Stephen Michigan, Savannah
Richard Jay Miller, Homer
William Woodhull Moore, Atlanta
Subramanyam Kommi Naidu, Atlanta
Alimam Butler Neal, Augusta
James Grant Parke, Jekyll Island
Jyoti M. Patel, Columbus
James Morris Perkins, Atlanta
Dionisio Arbon Pinero, Milledgeville
Quentin R. Pirkle, Atlanta
Edgar Bertram Powers, Norcross
Raimundo J. Ramirez, Tifton
Arepally Venkateswar Rao, Dublin
William Jerome Reed, Valdosta
Gerald Martin Rehert, Atlanta
Louis F. Reynaud, Atlanta
Virginia M. Gould Reynaud, Atlanta
Joseph Samuel Rowe, Atlanta
John Armitage Rusca, Atlanta
John Carl Sacra, Augusta
Manuel Valdez Salamanca, Columbus
Walter Thomas Sale, Atlanta
Philip Richard Saleeby, Brunswick
James Frederick Schwartz, Atlanta
Mercer Brannon Sell, Augusta
D. Gamini Seneviratne, Columbus
Walter H. Shehee, East Point
Nison Howard Shleifer, Atlanta
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Robert James Zimmerman, Macon

To understand one woman is not necessarily to understand any other woman.
J. S. Mill: *The Subjection of Women*, I, 1869

I've told this before . . .

Anna's Story

A FRIEND OF MINE, a gentle lady named Anna McKeown, was sick recently and spent some time in a local hospital. I visited her not long ago, and she told me a story which, like many things associated with the human condition, is infuriating, funny, and poignant — all at the same time. This is Anna's story:

You remember I had been in the hospital for several days, with a tube in my veins, and someone coming in every little while to check on me and give me my medicine. I'm 92, you know, and my breath was becoming short at times and real long at times. I'm certain that the nurses expected the Lord to come for me at any moment. I certainly thought so, and without a doubt He someday will, since I have become convinced that I am mortal.

So there I was, staring at the ceiling, picking at the bed covers, and feeling that I did not count for much in the world anymore. And I felt that it was not very important whether I did or did not care, anyway, since what was happening to me was inevitable, even though it was inconvenient. And then it started. Strange waves began to come over me, one after the other, and I felt terrible.

It was early morning when all of this happened. It seems like this is the time that most people die, and apparently it was now time for me. The Big Time. The Final Time. I was indeed a flower being picked for God's garden. And I knew it. I was as ready as I can get. Which, to tell you the truth, was not very ready.

I pushed the call button as my last act, and waited for Florence Nightingale to come in on rubber-soled shoes. I longed to simply hold someone's hand as I crossed the chasm between this world and the next.

A nice voice came over the intercom and said, "Yes, anything I can do for you?"

"Yes," I answered. "I'm dying, at least I think I'm dying. Won't somebody please come and give me something?"

But Florence was delayed, and her stand-in yelled at me over the intercom, "Just a minute."

"Just a minute." When the raven of gloom and eternal sleep was propped on Poe's door sill, at least the bird had the grace to say "Nevermore." And so, I waited, still longing for the touch of a human hand, and the soft and private slumber that must be the peace of a freezing man, began to ease me into eternity — until I was interrupted.

The door opened, and I saw the female form of a cleaning lady that looked to weigh something less than a half-ton GMC truck, with legs like small beer kegs. She was wearing rough work gloves, and she carried a mop. Her voice was somewhat less scratchy than millstones in action.

And she was all business with that mop. She mopped and mopped. But since people need people in desperate times, and since I needed someone to hold my hand and to ease me into Heaven with dignity and the love of a fellow creature, she would have to do (absent Florence). So I said, softly, with one of my last remaining breaths, "Please come over here and hold my hand. I'm dying."

Her response was not what I expected. In fact, there was no response at all for quite a while. She just kept scrubbing with that mop. I repeated my feeble moan, "I'm dying. Won't you *please* come hold my hand for just a minute?"

"Oh, get on with your dying. I ain't got no time to hold your hand. I got to clean up this room and get it ready. You don't need no help dying." Saying this, she finished her work and left.

Another wave started coming on just then, but this time it was anger — pure anger. I began to get strength, like Popeye eating spinach, and I got out of that bed and went to the door. As I opened it, I caught site of her skirts as she disappeared around the corner. I yelled after her, "You're just going to have to come back tomorrow and clean up again, because I'm not going to die."

I went back to my bed, picked up the phone, and ordered a pot of tea and a good breakfast and ate and drank the whole thing. My heart is as strong as garlic, and I take Inderal just to keep my doctor from nagging. And I'm going to keep eating popcorn. With salt. Florence can wait.

Susan J. Dillon
Managing Editor
Journal of the Medical Association of Georgia

(Editor's note: Others wishing to contribute to this page should send their stories to the attention of the Managing Editor of the Journal, *938 Peachtree St., NE, Atlanta, GA. 30309.)*



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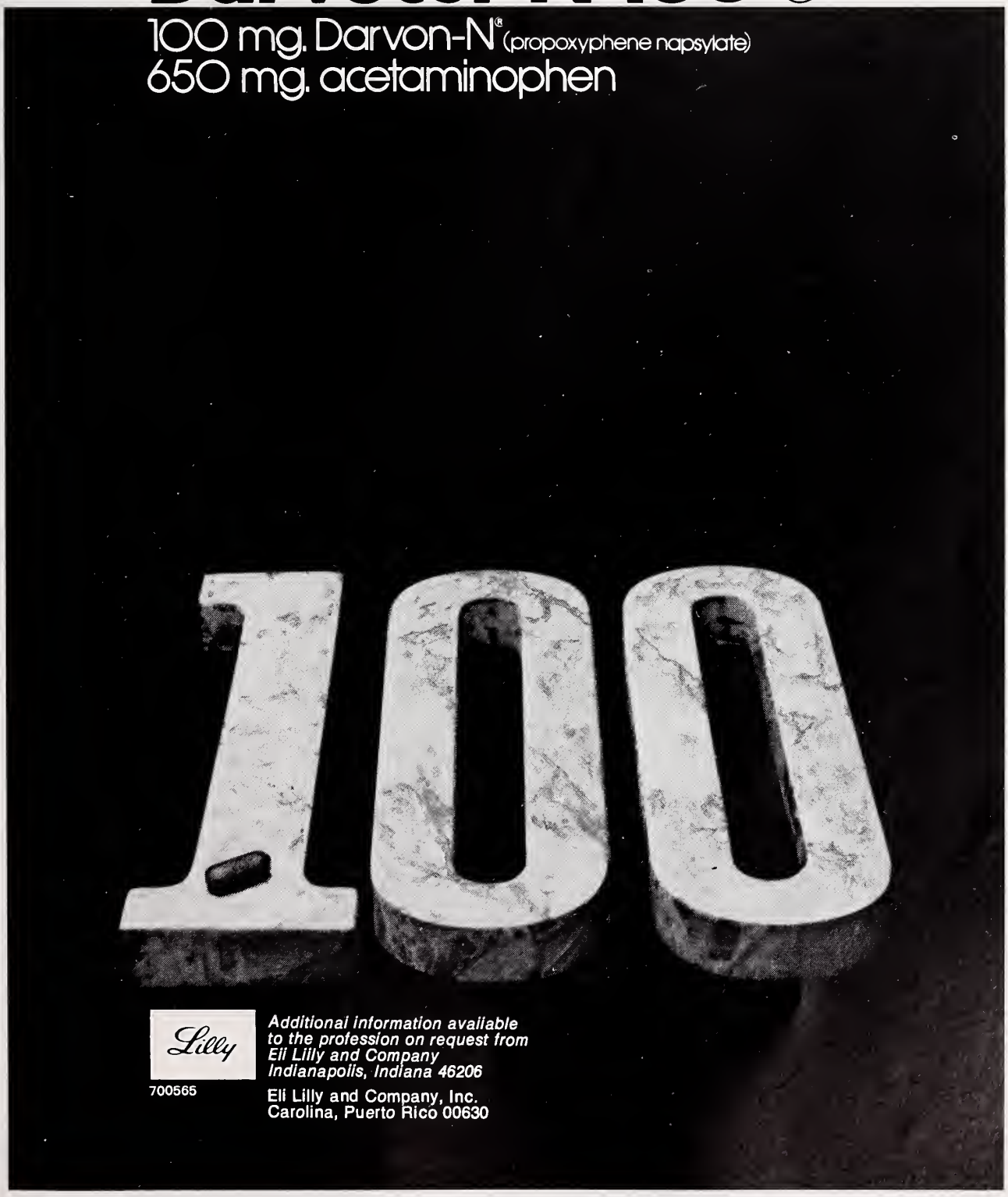
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TRIAVIL is contraindicated in CNS depression from drugs, in the presence of evidence of bone marrow depression, and in patients hypersensitive to phenothiazines or amitriptyline. It should not be used during the acute recovery phase following myocardial infarction or in patients who have received an MAOI within two weeks. Patients with cardiovascular disorders should be watched closely. Not recommended in children or during pregnancy. TRIAVIL may impair mental and/or physical abilities required for performance of hazardous tasks and may enhance the response to alcohol. Antiemetic effect may obscure toxicity due to overdosage of other drugs or mask other disorders. The possibility of suicide in depressed patients remains until significant remission occurs. Such patients should not have access to large quantities of the drug. Hospitalize as soon as possible any patient suspected of having taken an overdose.

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Please see following page for a brief summary of prescribing information.

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TRIAVIL® 4-25: Each tablet contains
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TRIAVIL® 4-10: Each tablet contains
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CONTRAINDICATIONS: Central nervous system depression from drugs (barbiturates, alcohol, narcotics, analgesics, antihistamines); evidence of bone marrow depression; known hypersensitivity to phenothiazines or amitriptyline. Should not be given concomitantly with a monoamine oxidase inhibitor since hyperpyretic crises, severe convulsions, and deaths have occurred from such combinations. When used to replace a monoamine oxidase inhibitor, allow a minimum of 14 days to elapse before initiating therapy with TRIAVIL. Therapy should then be initiated cautiously with gradual increase in dosage until optimum response is achieved. Not recommended for use during acute recovery phase following myocardial infarction.

WARNINGS: TRIAVIL should not be given concomitantly with guanethidine or similarly acting compounds since TRIAVIL may block the antihypertensive action of such compounds. Use cautiously in patients with history of urinary retention, angle-closure glaucoma, increased intraocular pressure, or convulsive disorders. Dosage of anticonvulsive agents may have to be increased. In patients with angle-closure glaucoma, even average doses may precipitate an attack. Patients with cardiovascular disorders should be watched closely. Tricyclic antidepressants, including amitriptyline HCl, have been reported to produce arrhythmias, sinus tachycardia, and prolongation of conduction time, particularly in high doses. Myocardial infarction and stroke have been reported with tricyclic antidepressant drugs. Close supervision is required for hyperthyroid patients or those receiving thyroid medication. May impair mental and/or physical abilities required for performance of hazardous tasks, such as operating machinery or driving a motor vehicle. In patients who use alcohol excessively, potentiation may increase the danger inherent in any suicide attempt or overdosage. Not recommended in children or during pregnancy.

PRECAUTIONS: Suicide is a possibility in depressed patients and may remain until significant remission occurs. Such patients should not have access to large quantities of this drug.

Perphenazine: Should not be used indiscriminately. Use with caution in patients who have previously exhibited severe adverse reactions to other phenothiazines. Likelihood of some untoward actions is greater with high doses. Closely supervise with any dosage. The antiemetic effect of perphenazine may obscure signs of toxicity due to overdosage of other drugs or make more difficult the diagnosis of disorders such as brain tumor or intestinal obstruction. A significant, not otherwise explained, rise in body temperature may suggest individual intolerance to perphenazine, in which case discontinue.

If hypotension develops, epinephrine should not be employed, as its action is blocked and partially reversed by perphenazine. Phenothiazines may potentiate the action of central nervous system depressants (opiates, analgesics, antihistamines, barbiturates, alcohol) and atropine. In concurrent therapy with any of these, TRIAVIL should be given in reduced dosage. May also potentiate the action of heat and phosphorous insecticides. There is sufficient experimental evidence to conclude that chronic administration of antipsychotic drugs which increase prolactin secretion has the potential to induce mammary neoplasms in rodents under the appropriate conditions. There are recognized differences in the physiological role of prolactin between rodents and humans. Since there are, at present, no adequate epidemiological studies, the relevance to human mammary cancer risk from prolonged exposure to perphenazine and other antipsychotic drugs is not known.

Amitriptyline: In manic-depressive psychosis, depressed patients may experience a shift toward the manic phase if they are treated with an antidepressant. Patients with paranoid symptomatology may have an exaggeration of such symptoms. The tranquilizing effect of TRIAVIL seems to reduce the likelihood of this effect. When amitriptyline HCl is given with anticholinergic agents or sympathomimetic drugs, including epinephrine combined with local anesthetics, close supervision and careful adjustment of dosages are required. Paralytic ileus may occur in patients taking tricyclic antidepressants in combination with anticholinergic-type drugs.

Caution is advised if patients receive large doses of ethchlorvynol concurrently. Transient delirium has been reported in patients who were treated with 1 g of ethchlorvynol and 75-150 mg of amitriptyline HCl.

Amitriptyline HCl may enhance the response to alcohol and the effects of barbiturates and other CNS depressants.

Concurrent administration of amitriptyline HCl and electroshock therapy may increase the hazards associated with such therapy. Such treatment should be limited to patients for whom it is essential. Discontinue several days before elective surgery if possible. Elevation and lowering of blood sugar levels have both been reported. Use with caution in patients with impaired liver function.

ADVERSE REACTIONS: Similar to those reported with either constituent alone.
Perphenazine: Extrapyramidal symptoms (opisthotonus, oculogyric crisis, hyperreflexia, dystonia, akathisia, acute dyskinesia, ataxia, parkinsonism) have been reported and can usually be controlled by the concomitant use of effective antiparkinsonian drugs and/or by reduction in dosage, but sometimes persist after discontinuation of the phenothiazine.

Tardive dyskinesia may appear in some patients on long-term therapy or may occur after drug therapy with phenothiazines and related agents has been discontinued. The risk appears to be greater in elderly patients on high-dose therapy, especially females. Symptoms are persistent and in some patients appear to be irreversible. The syndrome is characterized by rhythmical involuntary movements of the tongue, face, mouth, or jaw. Involuntary movements of the extremities sometimes occur. There is no known treatment for tardive dyskinesia; antiparkinsonism agents usually do not alleviate the symptoms. It is advised that all antipsychotic agents be discontinued if the above symptoms appear. If treatment is reinstituted, or dosage of the particular drug increased, or another drug substituted, the syndrome may be masked. Fine vermicular movements of the tongue may be an early sign of the syndrome. The full-blown syndrome may not develop if medication is stopped when lingual vermiculation appears.

Other side effects are skin disorders (photosensitivity, itching, erythema, urticaria, eczema, up to exfoliative dermatitis); other allergic reactions (asthma, laryngeal edema, angioneurotic edema, anaphylactoid reactions); peripheral edema; reversed epinephrine effect; hyperglycemia; endocrine disturbances (lactation, galactorrhea, gynecomastia, disturbances of menstrual cycle); altered cerebrospinal fluid proteins; paradoxical excitement; hypertension, hypotension, tachycardia, and ECG abnormalities (quinidine-like effect); reactivation of psychotic processes; catatonic-like states; autonomic reactions, such as dry mouth or salivation, headache, anorexia, nausea, vomiting, constipation, obstipation, urinary frequency or incontinence, blurred vision, nasal congestion, and a change in pulse rate; other adverse reactions reported with various phenothiazine compounds, but not with perphenazine, include grand mal convulsions, cerebral edema, polyphagia, pigmentary retinopathy, photophobia, skin pigmentation, and failure of ejaculation.

The phenothiazine compounds have produced blood dyscrasias (pancytopenia, thrombocytopenic purpura, leukopenia, agranulocytosis, eosinophilia); and liver damage (jaundice, biliary stasis).

Pigmentation of the cornea and lens has been reported to occur after long-term administration of some phenothiazines. Although it has not been reported in patients receiving TRIAVIL, the possibility that it might occur should be considered.

Hypnotic effects, lassitude, muscle weakness, and mild insomnia have also been reported.

Amitriptyline: Note: Listing includes a few reactions not reported for this drug, but which have occurred with other pharmacologically similar tricyclic antidepressant drugs and must be considered when amitriptyline is administered. *Cardiovascular:* Hypotension; hypertension; tachycardia; palpitation; myocardial infarction; arrhythmias; heart block; stroke. *CNS and Neuromuscular:* Confusional states; disturbed concentration; disorientation; delusions; hallucinations; excitement; anxiety; restlessness; insomnia; nightmares; numbness, tingling, and paresthesias of the extremities; peripheral neuropathy; incoordination; ataxia; tremors; seizures; alteration in EEG patterns; extrapyramidal symptoms; tinnitus; syndrome of inappropriate ADH (antidiuretic hormone) secretion. *Anticholinergic:* Dry mouth; blurred vision; disturbance of accommodation; increased intraocular pressure; constipation; paralytic ileus; urinary retention; dilatation of urinary tract. *Allergic:* Skin rash; urticaria; photosensitization; edema of face and tongue. *Hematologic:* Bone marrow depression including agranulocytosis; leukopenia; eosinophilia; purpura; thrombocytopenia. *Gastrointestinal:* Nausea; epigastric distress; vomiting; anorexia; stomatitis; peculiar taste; diarrhea; parotid swelling; black tongue. Rarely hepatitis (including altered liver function and jaundice). *Endocrine:* Testicular swelling and gynecomastia in the male; breast enlargement and galactorrhea in the female; increased or decreased libido; elevated or lowered blood sugar levels. *Other:* Dizziness, weakness; fatigue; headache; weight gain or loss; increased perspiration; urinary frequency; mydriasis; drowsiness; alopecia. *Withdrawal Symptoms:* Abrupt cessation after prolonged administration may produce nausea, headache, and malaise. These are not indicative of addiction.

OVERDOSAGE: All patients suspected of having taken an overdosage should be admitted to a hospital as soon as possible. Treatment is symptomatic and supportive. However, the intravenous administration of 1–3 mg of physostigmine salicylate is reported to reverse the symptoms of tricyclic antidepressant poisoning. Because physostigmine is rapidly metabolized, the dosage of physostigmine should be repeated as required particularly if life-threatening signs such as arrhythmias, convulsions, and deep coma recur or persist after the initial dosage of physostigmine. On this basis, in severe overdosage with perphenazine-amitriptyline combinations, symptomatic treatment of central anticholinergic effects with physostigmine salicylate should be considered.

J8TR31 (DC6613215)

For more detailed information, consult your MSD Representative or see full Prescribing Information. Merck Sharp & Dohme, Division of Merck & Co., INC., West Point, Pa. 19486.

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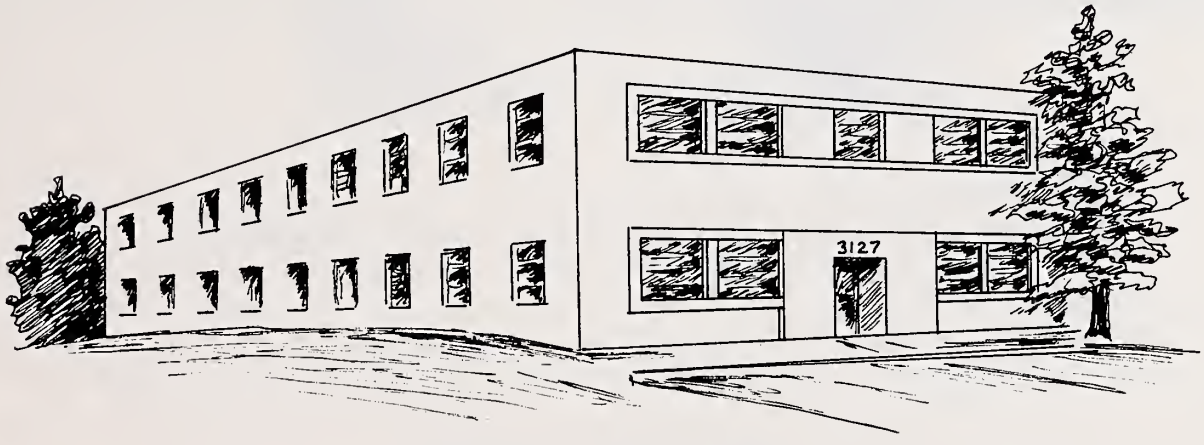
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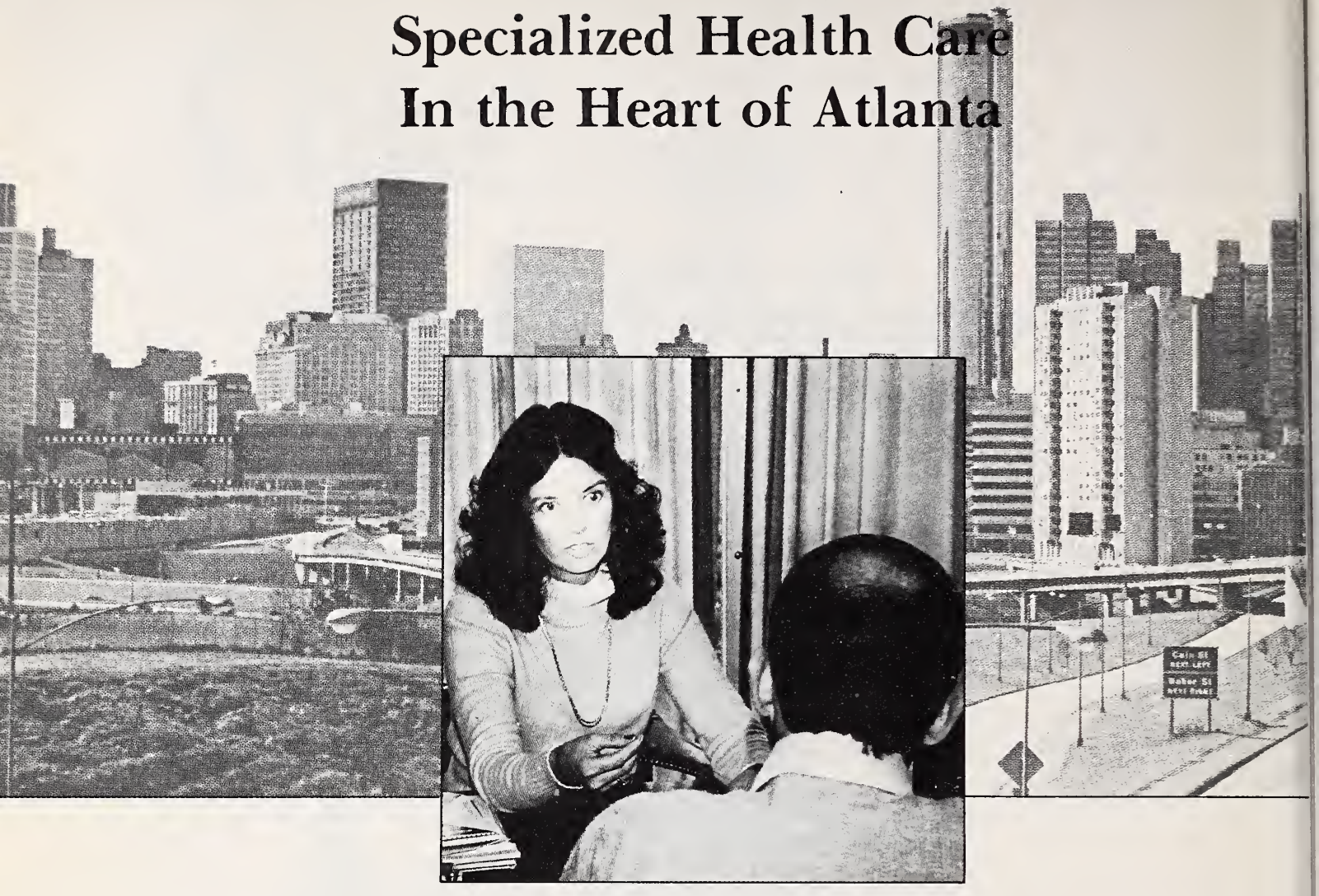
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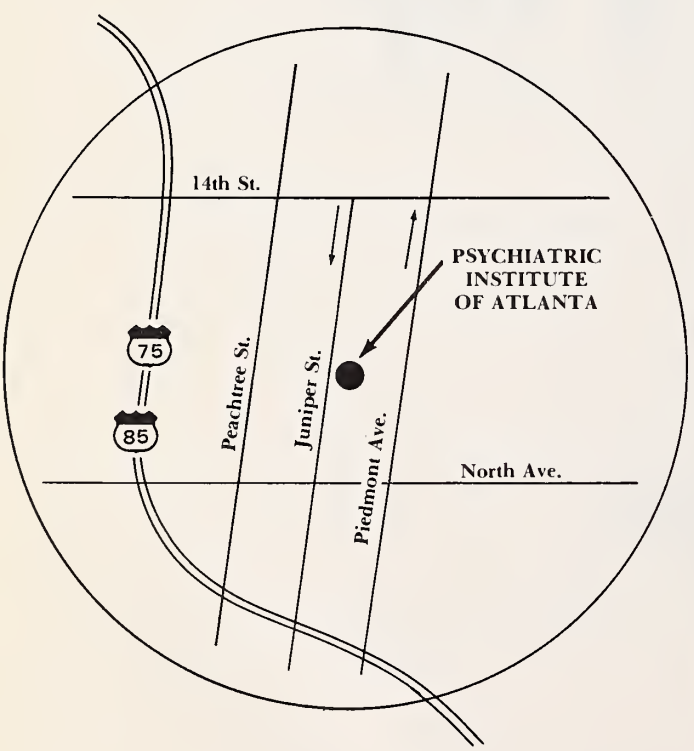


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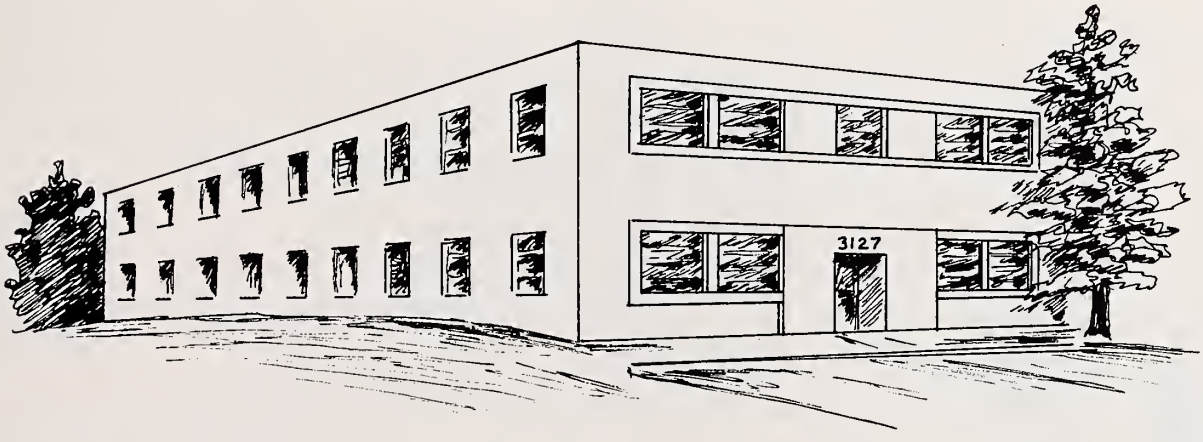
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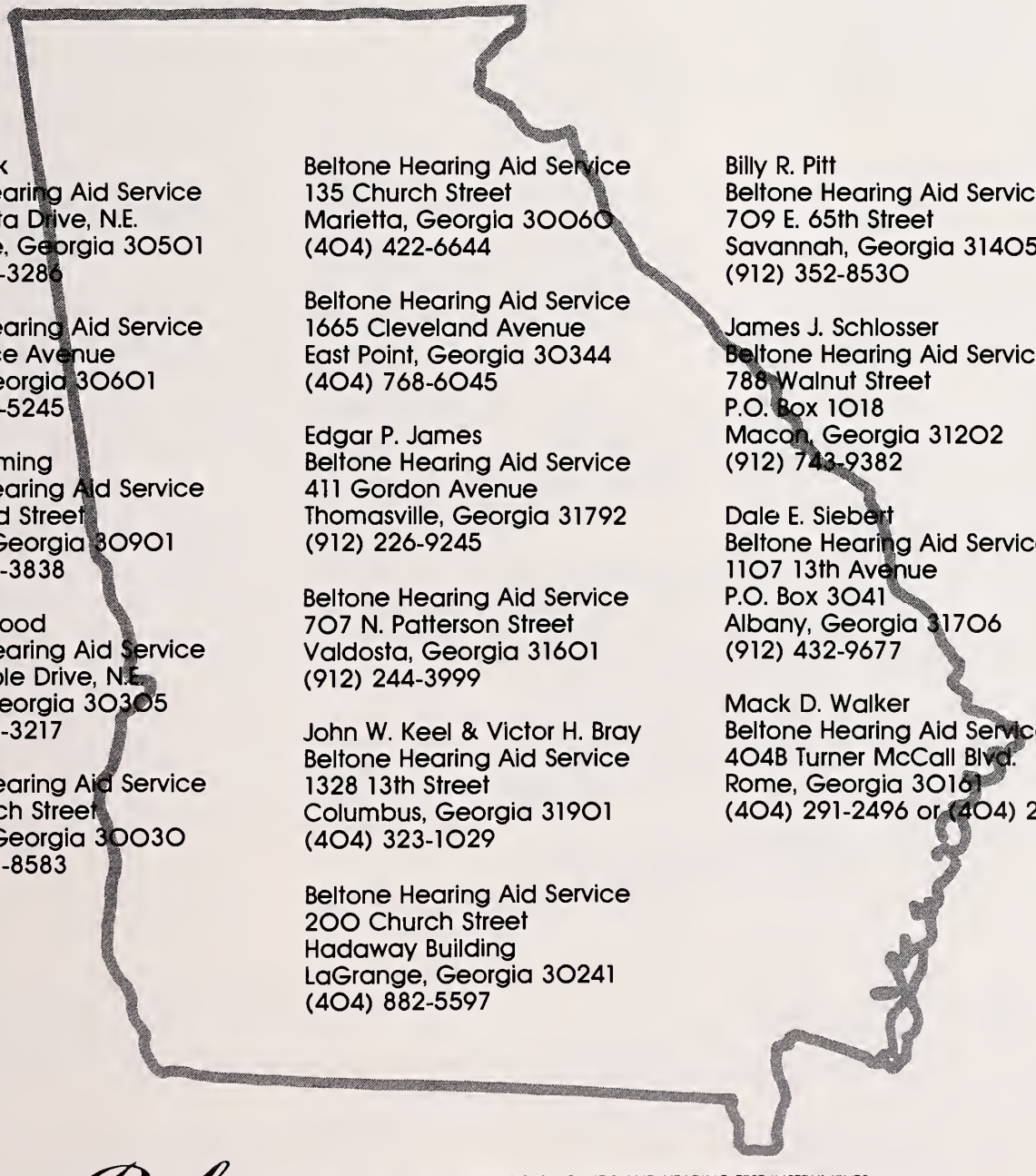
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Letter to the Editor . . .

MAG Member Disclaims PSRO Involvement

Dear Sir:

Please permit some comments on the article "PSRO — The Light at the End of the Tunnel Is in Sight" which appeared in the March issue [of the *Journal*].

In Section II of this article, it is stated that "PSRO's which had previously been foundations, as in Georgia, saw their roles as promoting and assuring quality care, while newer PSRO's saw their roles more as agents of the government in cost containment and policing the medical profession."

In my opinion, all will degenerate into cost containment organizations, functioning as handmaidens of the federal government.

In fact, it has already been litigated and adjudicated that physicians who participate in PSRO functions *are actually agents of the federal government*. If so, then they will do the federal government's bidding out of a cookbook of regulations and PSRO will not, in the long run, be self-governing.

In Section III, the PSRO is proposing to "delegate" hospital review to most present hospital review systems. If physicians accept this "delegation" in their local hospital, then they become part of the federal systems by becoming federal agents.

In Section IV, the author expressed his own doubts about PSRO in the next to last paragraph, and I share his feelings.

Apparently, so do most Georgia physicians because, despite repeated solicitation, only 2626 of the 6000 practicing physicians in Georgia have elected to "join" PSRO. I wonder how many of those who elected to participate have actually read the law? I suspect that most have not, or they would not opt to involve themselves in this "no-win" program.

For those who wish to protect themselves from involuntary participation in PRSO through "delegated" status, it is suggested that the following letter be sent:

TO:
Chairman of the Board of Trustees (of your hospital)
Administration (of your hospital)
President of the medical staff (of your hospital)
Members of the medical staff (of your hospital)
Chief executive officers of the PSRO (in your area)

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This statement is for the purpose of disclaiming any expressed or implied authorization to anyone to impair my right to contract on my own behalf without coercion, duress, or subterfuge on the part of any other person.

I hereby notify the above addressed authorities that I do not wish to be compensated by the federal government for my services to any of my patients and thereby am not required to comply with any guidelines and procedures enumerated in any statute or regulation pursuant to said statute.

I have been assured by a three-judge federal court decision, affirmed by the United States Supreme Court, that: "Underlying the constitutionality of (the PSRO law, P.L. 92-603) is the basic premise that each individual physician and practitioner has the ability to choose whether or not to participate in the program. The present statutory scheme does not impose criminal sanctions. Nor does it provide for severance from the medical profession for noncompliance. Rather, the instant legislation (PSRO) only sets forth conditions for being compensated by federal funds under the Medicare and Medicaid programs." [AAPS, Grinker, Shambaugh and Wolpert vs. Weinberger, Secretary of HEW, USDC (NDI77), 395 F. Supp 125 (1975)].

I choose not to participate, and I disclaim any attempt by anyone, now or in the future, either expressly or by implication, to represent that I, in any way, am a party to any agreement for implementing any part of the PSRO law or any regulations or directives promulgated pursuant to said law. Additionally, in order to protect my constitutional right against involuntary servitude, I hereby notify you that I have not and do not authorize anyone to contract for my services to perform any function for any PSRO or any other agency of the federal government.

physician's signature

This is a sad state of affairs, but it is going to get worse if we continue to do the government's police work either for free or for pay. The ultimate outcome is the same whether physicians *or others* ostensibly administer PSRO.

In this light, I feel that it is best to let others do it. Time will tell whether I'm right.

Cordially yours,
Milton I. Johnson, M.D.
Macon

MEDICAL MEETING CALENDAR

MAY

19—*Atlanta;* **SPRING WORKSHOP ON CHILDHOOD APHASIA;** Contact: Joan Kostmayer, Speech Pathologist, CCC, Atlanta Academy of Aphasia, 126 West Paces Ferry Road, N.W., Atlanta 30305. PH: 404/261-6803.

19-20 — *Savannah;* **AMA REGIONAL CME PROGRAM: PULMONARY FUNCTION TESTING AND BLOOD GASES, NEUROLOGY FOR PRIMARY CARE PHYSICIANS, OFFICE DERMATOLOGY, DIABETES, CARDIOVASCULAR DISEASE, HUMAN SEXUALITY, COMMON INFECTIONS, PRACTICE MANAGEMENT;** Category 1 credit; Contact: Dept. of Meeting Services, AMA, 535 N. Dearborn St., Chicago, IL 60610. PH: 312/751-6503.

24 — *Atlanta;* **PEDIATRIC HYPERTENSION — A REALITY;** Category 1 credit; Contact: American Heart Association, Georgia Affiliate, Broadview Plaza, Level C, 2581 Piedmont Rd., NE, Atlanta 30324. PH: 404/261-2260.

24-26 —*Atlanta;* **CLINICAL TOPICS IN GYNECOLOGY AND OBSTETRICS;** Category 1 credit; Contact: Associate Dean for CME, Emory Univ., 69 Butler St., S.E., Atlanta 30303. PH: 404/588-3534.

25-27 — *Kiawah Island, SC;* **SPRING MEETING, GEORGIA RADIOLOGICAL SOCIETY;** Category 1 credit; Contact: Edgar J. Filson, M.D., 9 Medical Arts Center, Savannah 31405.

26 — *Atlanta;* **THE PREVENTION, RECOGNITION, AND IMMEDIATE MANAGEMENT OF ATHLETIC INJURIES;** Category 1 credit; Contact: Associate Dean for CME, Emory Univ., 69 Butler St., S.E., Atlanta 30303. PH: 404/588-3534.

26-27—*Atlanta;* **PRIVATE ENTERPRISE PERSPECTIVES ON MEDICINE (PEP SEMINAR);** Category 1 credit; Contact: Sue McAvoy, Medical Association of Georgia, 938 Peachtree St., N.E., Atlanta 30309. PH: 404/876-7535.

29-31 — *Birmingham, AL;* **FAMILY PRACTICE REVIEW;** Contact: University of Alabama School of Medicine, University Station, Birmingham, AL 35294.

JUNE

4-9 — *Chattanooga, TN;* **FAMILY PRACTICE REVIEW;** Category 1 credit; Contact: University of Tennessee College of Medicine, Clinical Education Center, 921 E. Third St., Ste. 400, Chattanooga, TN 37403.

7-8 — *Pine Mountain, GA;* **PATIENT EDUCATION CONFERENCE;** Contact: Gerard R. Hummel, Southeastern Institute for Community Health, P.O. Box 1708, LaGrange 30241. PH: 404/637-6646.

7-9 — *Jekyll Island;* **INTERNAL MEDICINE;** Category 1 credit; Contact: Division of Continuing Education, Medical College of Georgia, Augusta 30901. PH: 404/828-3967.

8-10 — *Atlanta;* **EKG INTERPRETATION AND ARRHYTHMIA MANAGEMENT;** Category 1 credit; Contact: International Medical Education Corp., 64 Inverness Dr. East, Englewood, CO 80112. PH: 800/525-8646.

9-10 — *Pine Mountain;* **AMERICAN SOCIETY OF ANESTHESIOLOGISTS REGIONAL REFRESHER COURSE;** Contact: American Society of Anesthesiologists, 515 Busse Hwy., Park Ridge, IL 60068.

10-14 — *Atlanta;* **ANNUAL CONVENTION, AMERICAN SOCIETY OF COLON AND RECTAL SURGEONS;** Category 1 credit; Contact: American Society of Colon and Rectal Surgeons, 615 Griswold, Ste. 516, Detroit, MI 48226.

11-14 — *Hilton Head, SC;* **ANNUAL MEETING, GEORGIA STATE MEDICAL ASSOCIATION;** Contact: Sam O. Atkins, M.D., 2600 Martin Luther King Jr., Dr., Ste. 207, Atlanta 30311.

11-16 — *Nashville, TN;* **FAMILY PRACTICE INTENSIVE REVIEW;** Contact: Vanderbilt Continuing Education, 305 Medical Arts Bldg., Nashville, TN 37212. PH: 615/322-2716.

12 — *Knoxville, TN;* **NEW DEVELOPMENTS IN EMERGENCY MEDICINE, FAMILY PRACTICE, OPHTHALMOLOGY, PSYCHIATRY, SURGERY;** Category 1 credit; Contact: Knoxville Academy of Medicine, 422 W. Cumberland Ave., Knoxville, TN 37902.

17-21 — *Sea Island;* **FOURTH ANNUAL SYMPOSIUM ON LUNG DISEASE;** Category 1 credit; Contact: Associate Dean for CME, Emory Univ., 69 Butler St., S.E., Atlanta 30303. PH: 404/588-3534.

21-23 — *Lake Lanier;* **HYPERTENSION 1979: PRACTICAL MANAGEMENT CONSIDERATIONS FOR THE PHYSICIAN IN CLINICAL PRACTICE;** Category 1 credit; Contact: Dale E. Braddy, American College of Chest Physicians; 911 Busse Hwy., Park Ridge, IL 60068. PH: 312/698-2200.

22-23 — *Charleston, SC;* **ANNUAL UPDATE — FAMILY PRACTICE;** Contact: Medical University of South Carolina, 171 Ashley Ave., Charleston, SC 29403.

23-24 — *Jekyll Island;* **A SYMPOSIUM ON THE PSYCHOPATHOLOGY OF AGING;** Category 1 credit; Contact: Carl L. Crawford, M.D., Georgia Health Care Medical Directors Assoc., 1410 Russell Pkwy., Warner Robins 31093.

25-28 — *Atlanta;* **MEETING, SOCIETY OF NUCLEAR MEDICINE;** Contact: Mrs. M. Glos, 475 Park Ave. South, New York, NY 10016.

25-28 — *Orlando, FL;* **OB/GYN EMERGENCIES;** Contact: Dennis K. Wentz, M.D., UT Center for Health Sciences, 62 S. Dunlap St., Memphis, TN 38163. PH: 901/528-5605.

29-30 —*Myrtle Beach, SC;* **MEDICAL HORIZONS: HYPERTENSION AND CARDIOVASCULAR DISEASE;** Contact: Emery C. Miller, M.D., Bowman Gray School of Medicine, Winston-Salem, NC 27104.

JULY

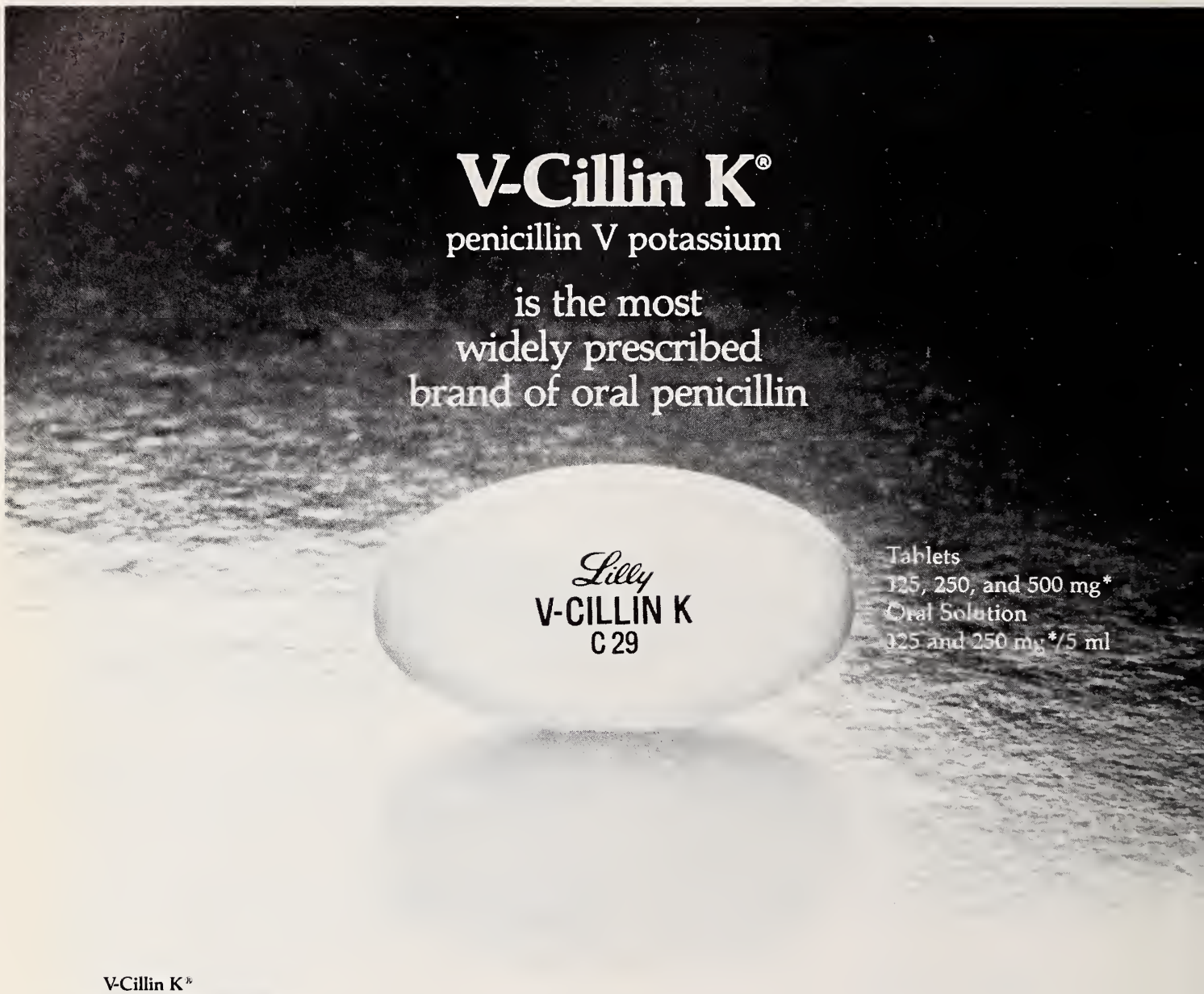
10 — *Knoxville, TN;* **NEW DEVELOPMENTS IN INTERNAL MEDICINE, OPHTHALMOLOGY;** Category 1 credit; Contact: Knoxville Academy of Medicine, 422 W. Cumberland Ave., Knoxville, TN 37902.

12-13 — *Atlanta;* **PHYSICAL IMPAIRMENT AND DISABILITY: ASSESSMENT AND PLACEMENT OF THE SEVERELY DISABLED;** Category 1 credit; Contact: Associate Dean for CME, Emory University School of Medicine, 69 Butler St., S.E., Atlanta 30303. PH: 404/588-3534.

13-15 —*Kissimmee, FL;* **CORONARY DISEASE, EXERCISE TESTING AND CARDIAC REHABILITATION;** Contact: International Medical Education Corp., 64 Inverness Dr. East, Englewood, CO 80110.

16-20 — *Jekyll Island;* **TAXES AND INVESTMENTS;** Category 1 credit; Contact: Division of Continuing Education, Medical College of Georgia, Augusta 30901. PH: 404/828-3967.

For additional information on these and other meetings, contact MAG, Division of Education 404/876-7535.



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Warnings: Serious, occasionally fatal, anaphylactoid reactions have been reported. Some patients with penicillin hypersensitivity have had severe reactions to a cephalosporin; inquire about penicillin, cephalosporin, or other allergies before treatment. If an allergic reaction occurs, discontinue the drug and treat with the usual agents (e.g., epinephrine or other pressor amines, antihistamines, or corticosteroids).

Precautions: Use with caution in individuals with histories of significant allergies and/or asthma. Do not rely on oral administration in patients with severe illness, nausea, vomiting, gastric dilatation, cardiospasm, or intestinal hypermotility. Occasional patients will not absorb therapeutic amounts given orally. In streptococcal infections, treat until the organism is eliminated (minimum of ten days). With prolonged use, nonsusceptible organisms, including fungi, may overgrow; treat superinfection appropriately.

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Actions. Antiminth (pyrantel pamoate) has demonstrated anthelmintic activity against *Enterobius vermicularis* (pinworm) and *Ascaris lumbricoides* (roundworm). The anthelmintic action is probably due to the neuromuscular blocking property of the drug.

Antiminth is partially absorbed after an oral dose. Plasma levels of unchanged drug are low. Peak levels (0.05-0.13 μg/ml) are reached in 1-3 hours. Quantities greater than 50% of administered drug are excreted in feces as the unchanged form, whereas only 7% or less of the dose is found in urine as the unchanged form of the drug and its metabolites.

Indications. For the treatment of ascariasis (roundworm infection) and enterobiasis (pinworm infection).

Warnings. *Usage in Pregnancy:* Reproduction studies have been performed in animals and there was no evidence of propensity for harm to the fetus. The relevance to the human is not known.

There is no experience in pregnant women who have received this drug.

The drug has not been extensively studied in children under two years; therefore, in the treatment of children under the age of two years, the relative benefit/risk should be considered.

Precautions: Minor transient elevations of SGOT have occurred in a small percentage of patients. Therefore, this drug should be used with caution in patients with preexisting liver dysfunction.

Adverse Reactions. The most frequently encountered adverse reactions are related to the gastrointestinal system.

Gastrointestinal and hepatic reactions: anorexia, nausea, vomiting, gastralgia, abdominal cramps, diarrhea and tenesmus, transient elevation of SGOT.

CNS reactions: headache, dizziness, drowsiness, and insomnia. Skin reactions: rashes.

Dosage and Administration. *Children and Adults:* Antiminth Oral Suspension (50 mg of pyrantel base/ml) should be administered in a single dose of 11 mg of pyrantel base per kg of body weight (or 5 mg/lb.); maximum total dose 1 gram. This corresponds to a simplified dosage regimen of 1 ml of Antiminth per 10 lb. of body weight. (One teaspoonful=5 ml.)

Antiminth (pyrantel pamoate) Oral Suspension may be administered without regard to ingestion of food or time of day, and purging is not necessary prior to, during, or after therapy. It may be taken with milk or fruit juices.

How Supplied. Antiminth Oral Suspension is available as a pleasant tasting caramel-flavored suspension which contains the equivalent of 50 mg pyrantel base per ml, supplied in 60 ml bottles and Unitcups™ of 5 ml in packages of 12.

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ORAL SUSPENSION



a drug of choice in pinworm infections

Please see brief summary of prescribing information on facing page.

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May & June, 1979 Meetings

May 2–3	**Connecticut State Medical Society** Hartford Hilton Hotel Hartford, Connecticut
May 2–5	**Medical & Chirurgical Faculty of the State of Maryland** Hunt Valley Inn Hunt Valley, Md.
May 3–5	**Oklahoma State Medical Association** Williams Center Tulsa, Oklahoma
May 3–6	**Texas Medical Association** Dallas, Texas
May 3–6	**Kansas Medical Society** Holiday Inn-Holidome Hutchinson, Kansas
May 3–6	**North Carolina Medical Society** Pinehurst Hotel Pinehurst, North Carolina
May 4–6	**Michigan State Medical Society** (House of Delegates) Kalamazoo Center Inn Kalamazoo, Michigan
May 6–10	**Mississippi State Medical Assoc.** Biloxi Hilton Biloxi, Mississippi
May 10–12	**Wisconsin State Medical Society** Marc Plaza Milwaukee, Wisconsin
May 16th	**Rhode Island Medical Society** Biltmore Plaza Hotel Providence, Rhode Island
May 17–18	**Minnesota Medical Association** St. Paul, Minnesota
May 23–27	**Florida Medical Association** The Diplomat Hotel Hollywood, Florida
June 6–8	**Alaska State Medical Association** Shee Atika Sitka, Alaska
June 7–10	**South Dakota State Medical Assoc.** Howard Johnson Rapid City, South Dakota
June 16–19	**Maine Medical Association** Samoset Resorts Rockport, Maine
June 18–20	**Iowa Medical Society** Tan-Tar-A Resort Osage Beach, Missouri
June 27	**Chicago Medical Society** (Annual Business Meeting & Inauguration) Starlight Inn Schiller Park, Illinois

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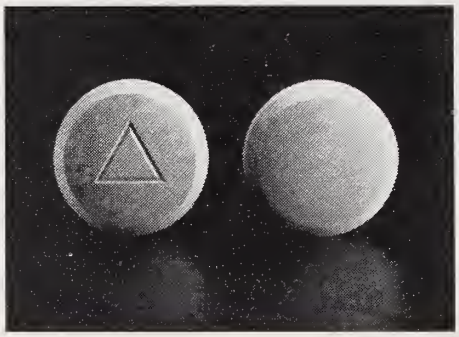
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The Maker

Examining a Few Myths About Prescribing.



Increasing pressure is being put on the practicing physician to prescribe drugs generically. You are told that brand–name products are universally "expensive" and generic versions are relatively "cheap." To make this case, the most extreme (rather than typical) price differentials are cited. Thus, consumers are led to believe that such differentials are commonplace. Even your knowledge and your motives as a physician are questioned.

Understandably, these views have created myths. We think it's time to examine them in the light of all the facts and ramifications.

MYTH: There are no differences in quality and performance between brand-name products and their generic counterparts. The corollary is that there are no differences among products made by high-technology, quality-conscious, research-based companies and those made by commodity-type suppliers.

FACT: The Food and Drug Administration does a good job in monitoring a generally excellent drug supply. Still, it has nowhere near the resources to guarantee the quality and bioavailability of all marketed products at any given time. Just a few months ago, for example, it noted that batches of tetracycline HCl capsules which met official monograph requirements were not bioequivalent to a reference product. As yo know, there is substanti literature on this subjec affecting many drugs, in cluding such antibiotics as tetracycline and erythromycin. The record o drug recalls and court actions affirms strongly that there are difference among pharmaceutical companies and their products. Research-intensive companies have far better records than those that do no re search and may practic minimum quality assur ance.

MYTH: Industry favors only "expensive" brand names and denigrates all generics.

FACT: PMA companies make 90 to 95 percent o the drug supply, includ-ing, therefore, most of t generics. Drug nomenclature is not the impor-tant point; it's the comp tence of the manufacturer and the integrity o the product that count.

Matters.

TH: Generic options al-st always exist.

CT: About 55 percent prescription drug ex-diture is for single-rce drugs. This ans, of course, that for y 45 percent of such enditure, is a generic scribing option avail-e.

TH: Generic scriptions are filled with pensive generics, thus ng consumers large s of money.

T: Market data show t you invariably scribe—and pharma-s dispense—both nd and generically eled products from wn and trusted rces, in the best inter-of patients. In most es the patient receives oven brand product. ings from voluntary nandated generic scribing are grossly ggerated.

MYTH: Drugs account for a major portion of the rise in health care costs.

FACT: Drugs represent a very small part of such costs. The amount of the health care dollar spent for prescription drugs was about 12 cents in 1967; today it is about 8 cents. And you as a physician are most conscious of how drug therapy can cut hospitalization, avert surgery, reduce office visits and keep patients on the job.

MYTH: Government intrusions into the marketplace will save tax money.

FACT: Government schemes always cost the taxpayer something, and the costs often exceed the benefits. Certainly, any federal "help," such as lists of wholesale drug prices sent to all physicians and pharmacists, will be no exception. Just think of the expense of keeping them current! Moreover, wholesale prices are poor guides to actual transaction prices and even worse guides to retail prices.

The PMA Position

We believe your freedom to prescribe, either by generic or brand name, should be totally unabridged. Otherwise, your prescribing prerogatives and your relationships with patients will be seriously impaired.

The maker does matter

After the myths about price and equivalency have been shattered, one fact stands out more clearly than ever: *The maker does matter.* As always, your best guide to drug therapy for your patients is to select products—both brands and generics—from manufacturers with credentials and performance records you have come to respect.

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JOURNAL
of the medical association of
georgia

Getting Together on Teenage Pregnancy

STEPHEN L. DANIEL, Ph.D., *Atlanta**

THIS SPECIAL ISSUE of the *Journal* on teenage pregnancy is the brainchild of a group of leaders from a number of organizations in the fields of medicine, health, and education. The Group on Health Education, as it calls itself, has been meeting regularly for the past 3 years at the Medical Association of Georgia (MAG) headquarters under the aegis of the MAG's Committee on Education. Discussion is always lively, and information sharing is probably the greatest benefit derived. Group members are often amazed at their lack of knowledge about what is going on in their field right here in Georgia. It seems that in this pluralistic age, we often find it hard to see the forest from behind our particular organizational trees.

In early 1978, group members felt the need to focus on a particular issue to give a sense of accomplishment in a cooperative venture. We selected the problem of teenage pregnancy, with its ramifications on the levels of the family, the school, the community, the church, and the health care system. Many new people came to our group and described operational or planned programs to deal with the problem. We learned a great deal from our discussions on teenage pregnancy and came to the conclusion that the problem was being adequately addressed by a variety of agencies.

It would be short-sighted not to share at least a part of what we learned with a wider audience. Therefore, teenage pregnancy is the theme of this issue of the *Journal*. (More on this subject will also appear in future issues of the *Journal*). Therefore, also, I have compiled the following "sampler" of activities in Georgia designed to help resolve the problems connected with teenage pregnancy. The sampling is my own, and omissions are not deliberate but due to my limited knowledge and information.

A Sampler of Activities Related to Teenage Pregnancy

The Department of Human Resources (DHR): The Georgia DHR's Division of Physical Health has a major commitment in the area of teenage pregnancy. The Maternal and Child Health Unit directs the Georgia Statewide Family Planning Program, which is organized into 19 district units for teenage pregnancy education and services. Each unit is assisted by a teen resource committee of leaders from the respective community. An informative workshop for all unit leaders was held in September 1978.

The Office of Health Education and Training contributed to the program with an excellent how-to-do-it handbook entitled *Cooperation Is the Key: A Handbook for Community Use in Reducing Teenage Pregnancy*. The same office also has a well-researched informational booklet by Dr. John Doby called *Teenage Sexuality and Teenage Pregnancy in the Nation and in Georgia* (1978). The booklet has a very useful annotated bibliography and address list of national organizations in the field. The DHR requested $1,000,000 for funding of teenage pregnancy programs in 1979-80, but as of early March 1979 the House Appropriations Committee had recommended only $250,000 (to establish four teenage clinics).

* Dr. Daniel is Assistant Executive Director for Education, Medical Association of Georgia, 938 Peachtree St., NE, Atlanta, GA 30309.

Council on Maternal and Infant Health: This council, established by the state legislature, works to encourage pregnant teenagers to seek prenatal care early to improve the outcomes of their pregnancies. It also participates in the DHR's teenage pregnancy programs and publishes the bi-monthly newsletter *Good Beginnings*.

Governor's Special Council on Family Planning: This is a state agency created in 1971 to act as an advocate in the provision of voluntary family planning services to all in need and to provide a statewide communication network on family planning legislation and funding. In August 1978, the Council sponsored a successful Community Awareness Conference on Teenage Pregnancy.

Gainesville Teen Program: The DHR's public health office in Gainesville has a clinic for teens with teenagers in charge.

Dalton Program: This excellent program for the Northwest Georgia Health District has as its primary focus the prevention of adolescent pregnancy through education. The program contains two basic components: the classroom educational program and adolescent counseling services. An upcoming issue of the *Journal* will feature a more detailed report of this 2½-year-old program.

Fernbank: Fernbank Science Center in Atlanta offers a variety of sex education programs for elementary and secondary school students, parents, teachers, Girl and Boy Scouts, nurses, and the general public. Topics include biology, home economics, sexually transmitted diseases, and birth control. Programs can be given at the site of the institution requesting the program.

Savannah Program: One of the 19 Statewide Planning Programs, this program has been involved in expanding reproductive education programs in the public schools, working with private schools to start similar programs, and informing the adult community about the problems spawned by teenage pregnancy. A more complete report of this program will appear in a future issue of the *Journal*.

Georgia State Obstetrical-Gynecological Society: See the article by Alton V. Hallum Jr., M.D., on page 396.

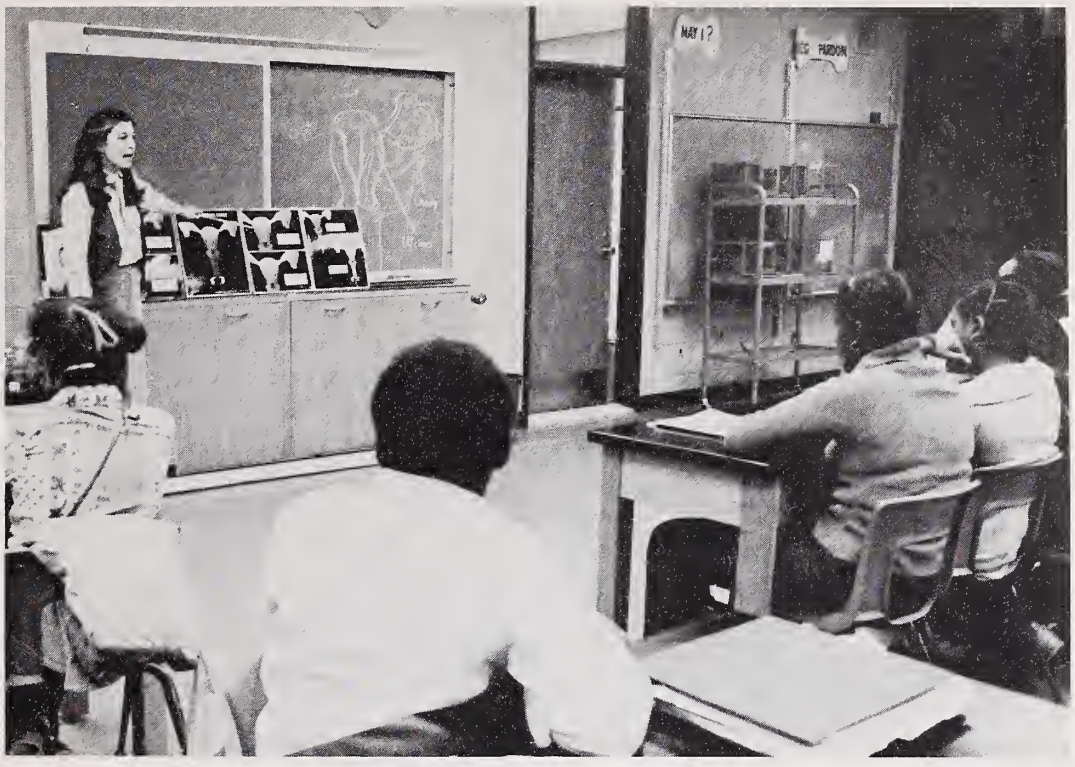
Georgia Department of Education: This state agency has funded pilot projects in 11 local school systems to develop educational programs in parenting and nutrition for adolescents and school-age parents. Each school system maintains the authority and responsibility of developing programs which reflect local concerns, needs, and resources. A local advisory committee of community leaders gives direction to each project. Enrollment in classes is on a voluntary basis, and students may be referred by principals, counselors, teachers, parents, and community agencies. Project coordinators follow up instruction by counseling, taking students to clinics at local health departments, and visiting young mothers in their homes. The experiences and findings of the pilot projects are being disseminated to other local school systems.

Health Improvement Through Education (HITE): Funded by a grant from the Kellogg Foundation, HITE is a health education team in Gwinnett County. It conducted a 3-day in-service program to teach teachers how to teach sexuality and has been involved in getting competency-based health education (including family life and sex education) into the Gwinnett County and Buford school systems, and in developing a teen education clinic with the county health department.

Atlanta Public Schools: The Atlanta school system uses a team from the Teenage Interconceptional Care Clinic at Grady Memorial Hospital to assist teachers in teaching all 8th graders from a discussion guide on human sexuality. Topics include maturation, physiology of the reproductive system, becoming a parent, family planning, and decision making. Last June, teachers completed a 50-hour course entitled, "Teaching and Counseling with Respect to Adolescent Sexuality, Reproduction, and Family Planning." Health curriculum guides for grades K-12 (including an element on family living and sexuality) are being prepared and will be ready for piloting by fall 1979.

MCG Maternity and Infant Care Project: As part of the Department of Obstetrics at the Medical College of Georgia in Augusta, this program provides medical and nursing care and educational, nutritional, and social work services to obstetric patients from the 13 rural counties surrounding Richmond County. A report on pregnant teenage patients in this project was published in the September 1977 issue of the *Journal*.

North Central Georgia Health Systems Agency (HSA): This Atlanta-based health planning agency has selected teenage pregnancy as a top priority area and is assisting consumers in identifying community resources and services in this area. It is also conducting a study of abortion and contraceptive counseling services to determine whether adequate information is being provided.



Teenagers learn about reproductive anatomy at the Teen Services Program at Grady Memorial Hospital.

Grady Teen Services Program: This program, also under the auspices of Grady's Department of Gynecology and Obstetrics, was developed specifically for teenagers and offers prenatal and obstetric care and information about pregnancy prevention. A detailed report from the director of this program will appear in a future issue of the *Journal*.

Grady Family Planning Program: Based in the Department of Gynecology and Obstetrics at Atlanta's Grady Memorial Hospital, this program provides the following services: physical examination, counseling, pregnancy testing, diagnosis and treatment of sexually transmitted infections, and weekly clinics and rap sessions for teens.

Grady Consultation and Education Team: This team, based in the Central Fulton Community Mental Health Center at Grady Hospital, is developing programs and services focused on promoting the mental health of children and adolescents. It conducted a community needs assessment, found teenage pregnancy to be a major concern, and is collecting information on community resources.

Red Cross: The Metropolitan Atlanta Chapter of the American National Red Cross offers a course for expectant parents which can be adapted for the high school classroom. The Red Cross also has volunteers teaching unwed pregnant teenagers at the Florence Crittenton Home in Atlanta and at the Douglas County Department of Family and Children Services.

MAG Auxiliary: The Auxiliary to the Medical Association of Georgia chose teenage pregnancy as its major health concern in 1978-79. Some Auxiliary members have been active on the DHR's district unit teen resource committees, and some county auxiliaries have purchased the film "What Happened to Our Time?" (on the Dalton program) for educational showings to various adult groups. The MAG Auxiliary has also been trying to get the American Medical Association Auxiliary to adopt teenage pregnancy education as its top priority.

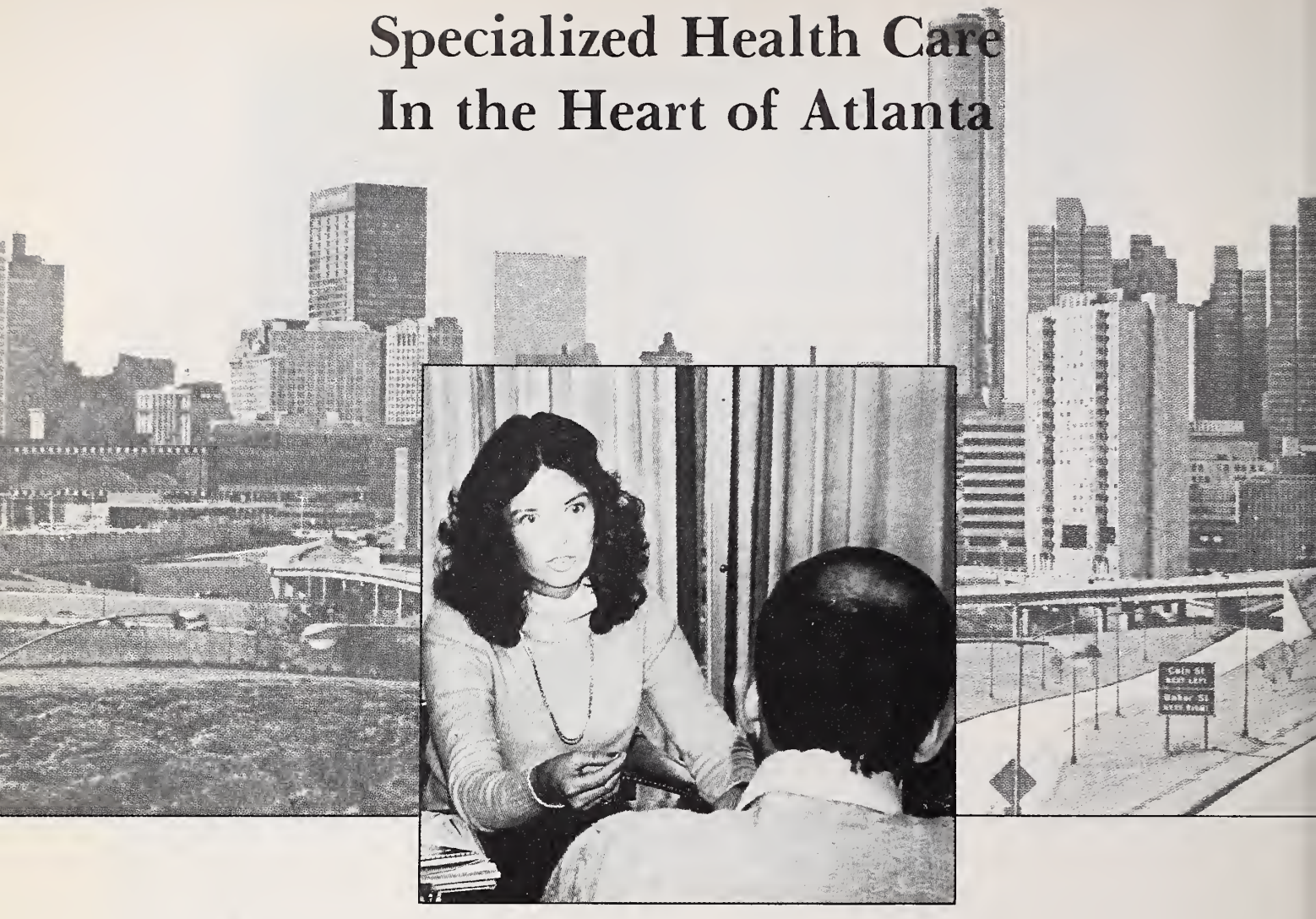
Affirmative Position on Parent Leadership Education (APPLE): This is an Atlanta organization offering counseling and training to men in family rehabilitation, family planning, and parenting. It sponsors the Prime Time Players, who put on short plays for children on a number of topics, including teenage sexuality.

Plays for Living: This is a community education project sponsored by Child Service and Family Counseling Center, Inc., a United Way organization in Atlanta. One of the plays available for booking is about an unwed mother and sexual responsibility.

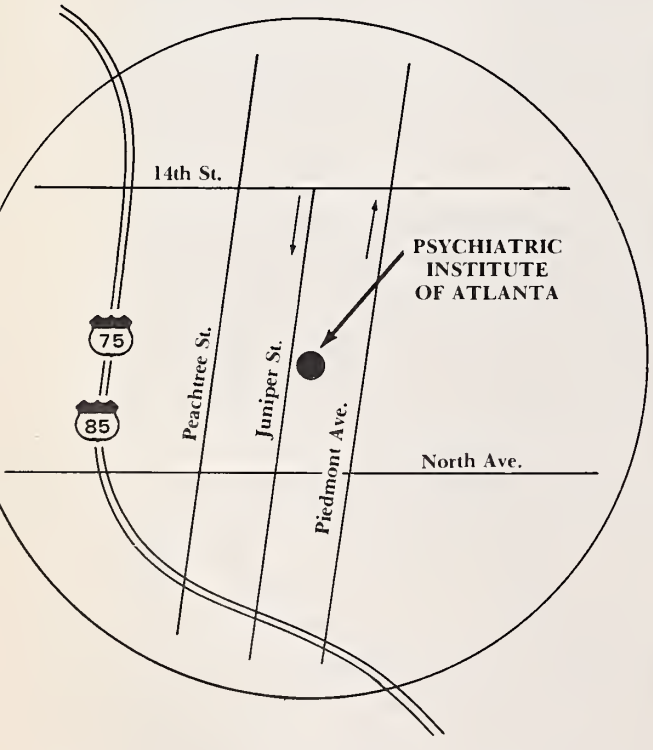
Planned Parenthood: This United Way agency offers counseling and educational services to any individual or family needing birth control information, sex education, moral support, and information in the event of an unwanted pregnancy. It cooperated with the DHR's Office of Health Education in the publication of the handbook *Cooperation Is the Key*.

March of Dimes: The National Foundation — March of Dimes has developed a new Preparenthood Education Program (PEP), which includes a kit designed for teenagers with materials on health care and nutrition during pregnancy.

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PRECAUTIONS: Evidence of untoward myocardial responses should be carefully watched for in all patients. In the presence of myocardial damage with atrial fibrillation or flutter, the ventricular rate may increase suddenly as the atrial rate is slowed; adequate digitalization reduces but does not abolish this danger. Ventricular tachysystole is particularly hazardous if myocardial damage exists.

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Bear in mind when treating ventricular arrhythmias in patients with severe organic heart disease and ventricular tachycardia that complete heart block, which may be difficult to diagnose, may be present. Since asystole may result if the ventricular rate is significantly slowed without attainment of regular atrioventricular conduction, procainamide should be stopped and the patient re-evaluated.

In the presence of both liver and kidney damage, normal dosage may produce symptoms of overdosage—principally ventricular tachycardia and severe hypotension.

A syndrome resembling lupus erythematosus has been reported with oral maintenance procainamide therapy. Common symptoms are polyarthralgia, arthritis and pleuritic pain. Fever, myalgia, skin lesions, pleural effusion and pericarditis may also occur. Rare cases of thrombocytopenia or Coombs-positive hemolytic anemia, possibly related to this syndrome, have been reported. Measure anti-nuclear antibody titers at regular intervals in patients on procainamide for extended periods of time or in whom symptoms suggestive of lupus-like reaction appear; in event of rising titer (anti-nuclear antibody) or clinical symptoms of LE, assess the benefit/risk ratio related to continued procainamide therapy (see boxed Warning). Steroid therapy may be effective if discontinuation of procainamide does not cause remission of symptoms. If the syndrome develops in a patient with recurrent life-threatening arrhythmias not otherwise controllable, steroid-suppressive therapy may be used concomitantly with procainamide.

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A syndrome resembling lupus erythematosus has been reported in patients on oral maintenance therapy (see Precautions). Reactions consisting of fever and chills have been reported, including a case with nausea, vomiting, abdominal pain, acute hepatomegaly, and a rise in serum glutamic oxaloacetic transaminase following single doses of the drug. Agranulocytosis has been occasionally reported following repeated use of the drug, and deaths have occurred. Therefore, routine blood counts are advisable during maintenance procainamide therapy; and the patient should be instructed to report any soreness of the mouth, throat or gums, unexplained fever or any symptoms of upper respiratory tract infection. If any of these symptoms should occur and leukocyte counts indicate cellular depression, procainamide therapy should be discontinued and appropriate treatment should be instituted immediately. Bitter taste, diarrhea, weakness, mental depression, giddiness, psychosis with hallucinations, and hypersensitivity reactions such as angioneurotic edema and maculopapular rash have been reported.

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Teenage Pregnancy in Georgia: Defining the Problem

BRIAN J. McCARTHY, M.D., BETTY ABBOTT, M.S.P.H., M.B.A., and JULES S. TERRY, M.D., M.P.H., *Atlanta**

Introduction

TEENAGE PREGNANCY with its attendant adverse medical, social, and economic consequences for the adolescent and her offspring continues to be of concern in this state. We shall attempt to define the extent of the problem and its consequences for teenagers in Georgia. First, we shall present national data because much important information, unavailable for Georgia, has been learned about adolescent childbearing through national surveys. We shall then present data for Georgia and discuss its implications and make specific recommendations which may ameliorate the problem.

The National Problem

Nationwide, approximately 1 million teenagers (10%) become pregnant each year, and 6% give birth. Among the 22 most industrialized countries in the world, there are only four countries with a higher teenage fertility rate than the United States. Slightly more than 50% of the 21 million people between the ages of 15 and 19 years in the United States are sexually active. About 60% of these are males, and 40% are females. Another 2 million 13- to 14-year-old boys and girls are believed to be sexually active.[1]

One-third of the pregnancies in 15- to 19-year-olds terminate in a legal abortion, and 25% of the pregnancies result in out-of-wedlock births. In addition, during 1976, girls younger than 15 years of age gave birth to almost 12,000 live infants.[2] At the same time, they terminated an equal number of pregnancies by induced abortion.[3] As a result of the high rate of teenage pregnancy, almost 1 in 5 births in the United States are to teenagers.

Nationwide, nearly 75% of unmarried teenagers state that their pregnancies were not intended. Even among married teenagers, fewer than 60% intentionally become pregnant. For more than 50% of the births to 15- to 19-year-olds, the pregnancies were unintended during any year.[4]

The age of the woman at the time of the first birth is vitally important. Pregnancy during adolescence is more dangerous for both infants and mothers than pregnancy after age 19. The infant mortality rate for first-born babies of teenage mothers is much higher than the rate for infants of women who are in their early twenties. In addition, higher-order births to teenagers are associated with an increasing infant mortality rather than the decreasing infant mortality pattern seen as parity increases in an older woman.

"There have been over 26,000 pregnancies in Georgia teens each year since 1974."

The rate of premature birth is much higher for teenagers. As a result, teenagers, who bear 19% of all infants in the United States, have 24% of all low-birth-weight babies.[6]

In addition to the infant risk associated with adolescent childbearing, there are significant increases in maternal morbidity and mortality. The maternal death rate is 60% higher for women who become pregnant before they are 15, while the rate for 15- to 19-year-olds is 13% greater than for women in their early 20's. Teenage mothers are more likely to die

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from toxemia, hemorrhage, and miscarriage than older mothers. They also have a higher complication rate during labor and are more likely to be anemic and experience nonfatal toxemia during their pregnancy.[1]

Eighty percent of the girls who become pregnant while in high school never complete their high school education. Pregnancy is the single most common reason cited for a female teenager to drop out of school. The younger the teenager, the more likely she is to drop out because of pregnancy.[1] The

"Eighty percent of the girls who become pregnant in high school never complete their high school education."

lack of education may be a major step in the development of welfare dependency. Unemployment rates are higher for these adolescents than their contemporaries without children, and approximately 72% of mothers who first gave birth at age 15 to 17 are receiving welfare.[1] This is more than 4 times the rate for women who first gave birth at ages 20 to 24. Additional economic studies show that the younger the woman at the first birth, the poorer the family is likely to be in the future. This economic hardship is compounded by the fact that 60% of all teenage marriages result in divorce within the first 5 years. The teenager with a prenuptial conception is even more likely to have her marriage broken. Unfortunately, not only are these teenagers subjected to a more stressful pregnancy and child-rearing experience, they are more likely to have more children than their contemporaries who begin childbearing after age 20.[1]

The Problem in Georgia

In 1977, over 239,000 Georgia women were between the ages of 15 and 19; this group constituted 20% of the state's childbearing population (an estimated 1,183,100 women 15-44 years of age). By applying national figures, estimates of the number of sexually active teenagers and the levels of contraceptive knowledge and usage can be derived for 15- to 19-year-old women in Georgia.[5] During 1977, approximately 95,000 teenage women were married. Based on national surveys, an estimated 35% nationwide, or an estimated 50,000 in Georgia, of the never-married women aged 15 to 19 were sexually active. Of never-married women aged 15 to 19, 60% nationwide, or an estimated 85,500 in Georgia, could not correctly identify the time of their greatest pregnancy risk within their menstrual cycle. Contraceptive use among these sexually active, never-married women was also limited. Only 30% of these women always used contraception, and 26% (14,300) had never used any contraception.

There have been over 26,000 pregnancies in Georgia teens each year since 1974. In 1977, girls under age 15 gave birth to 608 infants in Georgia. Adolescents 15-19 years of age gave birth to 18,242 live infants; that is, 1 in 12 girls aged 15-19 years had a baby. These births constituted 23% of all Georgia births. Adolescents living in Georgia obtained one-third of the state's 25,552 abortions in 1977.

Figures 1 and 2 illustrate trends in reported conceptions and in the rates of conception and fertility for Georgia teenagers since 1969.† Females 10-to-14 years old have experienced an increase in fertility from 1969 to 1973, and this was followed by a slight decrease until the present. The conception rate doubled from 1969 to 1976, but has begun to decline. The decline in the fertility rate during the years 1974 and 1975 may be attributed to the increase in abortion among these teens.[7] For teens aged 15-to-19 years, the decline in the fertility rate has been more dramatic, but the conception rate has risen along with an increased incidence of abortion.

"The estimated intended fertility rate of 49.4 per 1,000 live births to 15-19 year olds represented 11,840 births in 1974."

In Georgia, births to teenagers constituted one-half of the out-of-wedlock births. There was a trend toward an increase in the number of out-of-wedlock births among teenagers, which was especially notable for young teens. In 1977, 7 of 10 live births to teens 10-14 years old were out-of-wedlock, and 32% of teens 15-19 years old giving birth were unmarried.

More important than wedlock status is the high rate of intended fertility reported in Georgia by these teens.[8] Georgia ranked third overall among the states in fertility for females aged 15-19 in 1974, but first in intended fertility for that age group. The estimated intended fertility rate of 49.4 per 1,000 live births to 15-19 year olds represented 11,840 births in 1974.

As a review of pregnancy patterns described thus far, one can examine projected fertility for today's teenagers at current rates. Based on the single-year, age-specific fertility rates for 1977, of the cohort of females who were 12 years old in 1977, an average of 1 in 6 will have a live birth before her 18th birthday. In this same cohort, 1 in 8 will have an induced abortion before her 18th birthday.

† Data are not available for trends in out-of-state abortions, illegal abortions, or other unreported conceptions. The conception rate is calculated as the number of pregnancies to teens per 1,000 teenage women; the fertility rate is the number of live births to teens per 1,000 teenage women.

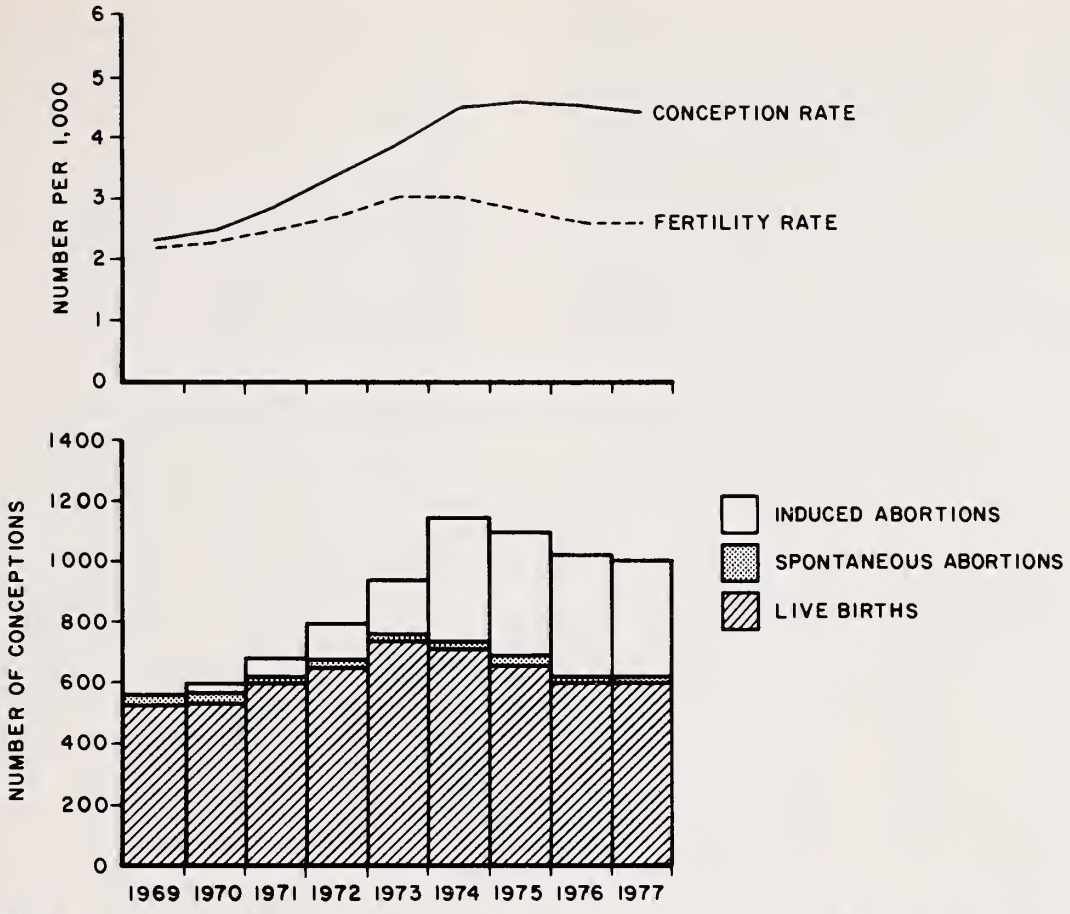


Figure 1 — Reported conception and fertility rates and number of reported conceptions, by outcome, for females aged 10-14 years, all races, Georgia, 1969-1977.

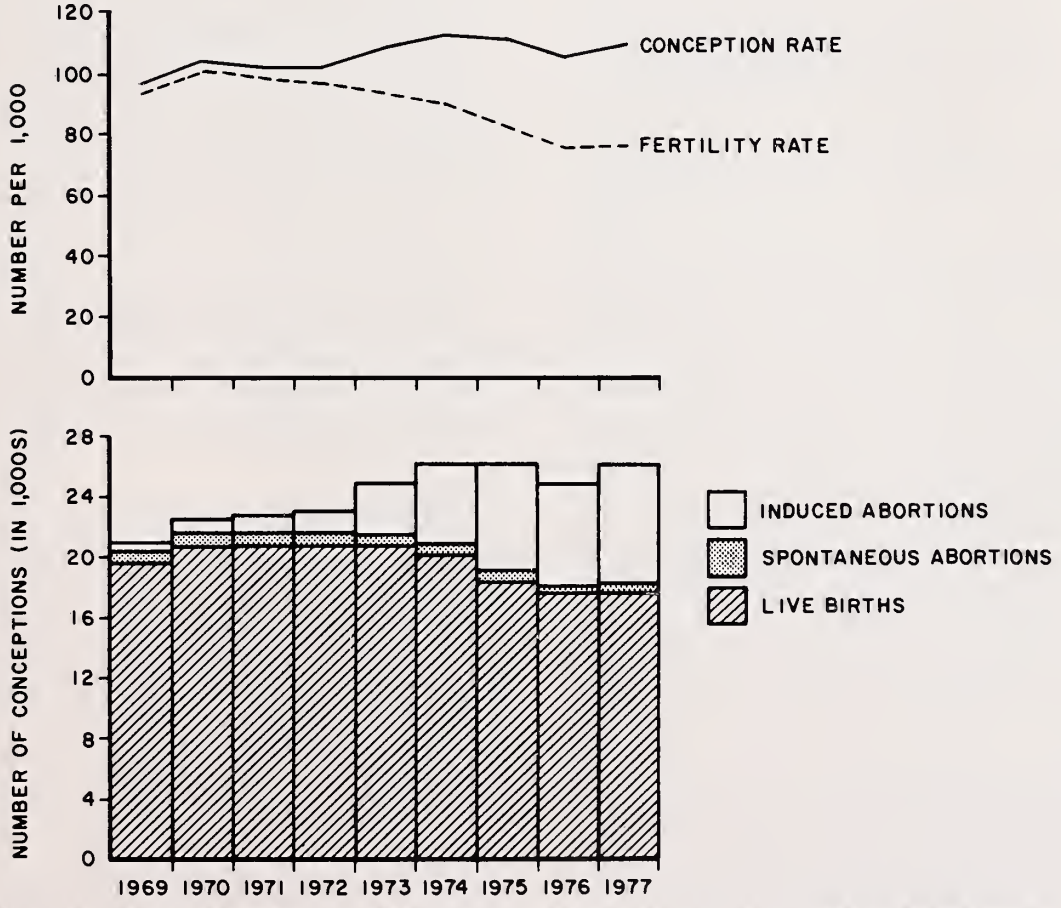


Figure 2 — Reported conception and fertility rates and number of reported conceptions, by outcome, for females aged 15-19 years, all races, Georgia, 1969-1977.

Other health consequences of early sexual activity among females are serious. Teenage gonorrhea in Georgia accounted for 27% of all reported cases in fiscal year 1976. Epidemiologic studies have shown that the earlier a woman begins sexual activity, the more likely she is to experience carcinoma of the cervix.[9]

Pregnant teenagers also run a higher risk of complications of pregnancy than do other women.‡ Table 1 displays the overall rates of pregnancy and labor complications, infant mortality rates, and prematurity rates by selected maternal age and race categories for 1974-1976 for Georgia women.

10-19 is higher than the rate for white infants of teenaged mothers, with 76 more infants per 1,000 weighing less than 2,500 grams. On the whole, teenaged women had one-third of the premature infants in Georgia in 1977, and 6,857 premature births would have been avoided in the period 1974-1976 if prematurity rates of teenage births had been the same as those of 20-24-year-olds.

Infants of teenagers in Georgia experience an increased risk of death, as do infants of teenagers across the nation. Infants of young teenagers are almost twice as likely to die in the first 28 days of life as infants of women 20-24 years of age. The post-

TABLE 1—SELECTED PERINATAL AND INFANT HEALTH INDICATORS,* BY MATERNAL AGE AND RACE
Georgia, 1974-1976

Maternal Age	Complications Related to Pregnancy		Complications of Labor		Prematurity		Neonatal Mortality Rate		Post-neonatal Mortality Rate		Infant Mortality Rate	
	White	Black	White	Black	White	Black	White	Black	White	Black	White	Black
10-14	73.1	127.0	87.9	93.8	106.7	170.4	15.0	27.5	10.7	12.8	25.7	40.3
15-17	63.7	98.2	85.3	78.0	94.4	158.2	17.5	21.8	6.9	11.3	24.4	33.1
18-19	60.6	88.9	82.8	77.7	74.8	146.3	11.6	17.6	6.2	10.4	17.8	28.0
20-24	48.6	75.6	82.7	72.8	62.3	124.5	9.7	17.9	3.6	7.5	13.3	25.2
Total	50.4	84.4	83.0	79.6	65.7	132.0	10.1	18.5	3.6	8.1	13.7	24.6

* Indicators are expressed as rates per 1,000 live births and are for completed information.

Although younger women experienced higher rates of complications related to pregnancy, the most noteworthy differences in the table are the discrepancies between white and black women. Younger black females experienced nearly twice the complication rate of white females. Although complication rates decrease with age, blacks had higher rates than their white peers.

The pregnancy complications most frequently reported for teenagers were anemia and toxemia. Younger pregnant women were from 1.5-3 times more likely to have anemia as women 20-24 years of age, and twice as likely to have toxemia. Complications of labor were also more frequent among teenagers, regardless of race. For these complications of labor, differences between blacks and whites were less pronounced than differences between younger and older women of the same race.

Health consequences for infants of teenage mothers must also be examined. These infants are more likely to have a low birth weight. Teenagers 10-to-14 years of age had almost twice the rate of prematurity compared with 20- to 24-year-olds. The prematurity rate for black infants of women aged

neonatal mortality for infants of 10- to 14-year-olds is 2.5 times higher than the rate for infants of women 20-24 years. Therefore, not only is every pregnancy in this group high risk, but every infant of women in this group should be identified as high risk.

Data for Georgia are not available to evaluate the social and economic consequences of adolescent pregnancy. No data are available regarding the school drop-out rate due to pregnancy, or the number of teenage mothers receiving Aid to Families With

"The postneonatal mortality for infants of 10 to 14 year olds is 2.5 times higher than the rate for infants of women 20-24 years."

Dependent Children (AFDC) payments. The only indicator easily available was data from the State's Child Abuse Registry for July 1975 through June 1977. This registry is compiled from social services investigation of physical or sexual abuse, but does not include reports of neglected children. Three findings are noteworthy. Only 10% of the natural mothers who were confirmed abusers were teenagers. However, 53% of the natural mothers who were confirmed abusers had had a teenage pregnancy. Those families in which the natural mother had had a teenage pregnancy showed an unstable family composition; in only 30% of the cases were

‡ The data for this analysis were obtained from the standard birth and death certificates for 1974-1976 and death certificates for 1977, which are maintained by the Georgia Department of Human Resources. Complication rates are based on the reporting of one or more complications related to pregnancy, which include pre-eclampsia, eclampsia, RH sensitization, syphilis, rubella and other viral infections, anemia, and a broad category of undefined "others." Complications of labor include abruptio placentae, placenta previa, prolapse or compression of the cord, dystocia, breech, maternal hypotension, prolonged labor, or intrapartum fever.

both parents present, and in 48% of the cases only the natural mother was present.

Discussion

The increased rates of maternal and infant mortality and morbidity associated with adolescent pregnancy justify the great concern that exists in Georgia over the issues surrounding teenage pregnancy. Teenage childbearing and childrearing affect everyone in this state from a social and economic standpoint. School dropout, unemployment, underemployment, and the potential for child abuse pose a threat to the health and welfare of society.

We have described the population at risk — in this case, the pregnant teenager and her infant. Those most at risk are the very young and the black adolescent. While race cannot be implicated as responsible for poor pregnancy outcomes, our data indicate that the black teenager and her infant currently represent a population at greater risk than the white teenager and her offspring. Likewise, the very young adolescent, regardless of race, presents as a high-risk candidate for obstetrical care.

From a health standpoint, adolescent sexual activity and childbearing are hazardous. The earlier the first pregnancy occurs, the higher the woman's total fertility and the more closely spaced the subsequent pregnancies. Higher lifetime fertility for those least prepared to support a family increases the social burden of those families. It may also be true that closely-spaced pregnancies are higher-risk pregnancies with an increased incidence of mortality and morbidity. The high rate of intended fertility among Georgia teens suggests a lack of adequate information about the risks of adolescent childbearing. Although decreasing unwanted fertility may be approached through such avenues as improved family planning services to teens, intended fertility is a more difficult issue to resolve. Since more optimal pregnancy outcomes may be obtained by delaying childbearing until the 20's, it is essential that each teen make an informed decision about sexual activity and childbearing.

The increasing use of abortion by teens to control fertility also has risks. Although a decrease in teenage fertility has been observed over the last several years, an increase in reported conceptions has occurred. Even though induced abortion is a less desirable means of fertility control than averting pregnancy, based on current conception patterns, a woman who was 15 years old in 1976 has a 40% chance of having at least one induced abortion during her reproductive years.[11] The long-term risks associated with abortion are still uncertain, and any unnecessary exposure should be avoided. There are some indications that the high abortion-to-live-birth ratio for teens is based in part on the use by some teens of abortion as a primary means of birth control.

Health providers, especially practitioners, should be alert for opportunities to encourage decision-making regarding sexual activity, contraception, and childbearing. As prominent members of the community, they should focus attention on adolescent health issues, and encourage the community to provide services which are sensitive to the problems of adolescents and appropriate for them. This includes careful monitoring for high-risk conditions, and particular regard for confidentiality, special education, and comprehensive support services which may include long-term follow-up of the infants of some of these adolescents.

Any solution to a serious problem is dependent upon a clear understanding of the nature of the problem. Certainly the consequences of adolescent pregnancy deserve attention, but if one does not maintain an appropriate perspective, treatment of mere symptoms of a greater problem can be totally consuming. The real issues — the teenager's development of the ability to make decisions and form his/her own value system — should not be overlooked. Our society must accept the responsibility of attempting to influence the various choices that our adolescents face in a manner that develops their decision-making capability. This concept has been presented by Howard[12] and is summarized here.

". . . the earlier a woman begins sexual activity, the more likely she is to experience carcinoma of the cervix."

The first decision is whether to become sexually active. Few adolescents are even aware that this is a choice, and even if they are, society does not choose to support them in a manner that respects their dignity as a person. Often society attempts to control the adolescent through reward or punishment instead of expressing confidence in the teen's ability to make appropriate choices if given objective information. Continuing support is required, for the decision of whether to be sexually active or not is recurrent.

The second decision is dependent on the first. If a teen chooses to be sexually active, he/she should decide whether to use contraception. This decision centers on the question of whether a pregnancy is desired. We have presented data to suggest that a large number of 15- to 19-year-old women want to become pregnant. We feel that there is sufficient evidence to justify making a concerted effort to influence these teens to at least delay their childbearing until their 20's. This may mean providing other alternatives, like job and educational opportunities,

that demonstrate society's belief that they can make a real contribution. On the other hand, if they do not want to become pregnant, adolescents should be encouraged to use contraception. The failure to use contraception will result in adolescents having to make decisions regarding abortion, adoption, or the responsibility of rearing a child. Large numbers are choosing abortion with its yet undetermined risks; fewer are choosing adoption, and the stress of childbearing is being documented. In our opinion, the adolescent should never have to make a decision beyond the second choice.

In conclusion, we have presented data that document the hazards of adolescent pregnancy. No one will refute the problems it can cause. But perhaps adolescent pregnancy itself is a symptom of an even greater problem, the lack of having developed in our adolescents the ability to make decisions, the process by which they will develop their own value system.

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While contraception alone will not solve the teen pregnancy problem, contraceptives are an important part of the minimization of this problem.

Toward Solving Teenage Pregnancy in Georgia

ROBERT A. HATCHER, M.D., M.P.H., JACOB B. ADAMS, M.D., M.S.P.H., and MONICA S. OAKLEY, R.N., B.S.N., F.R.N.P., *Atlanta**

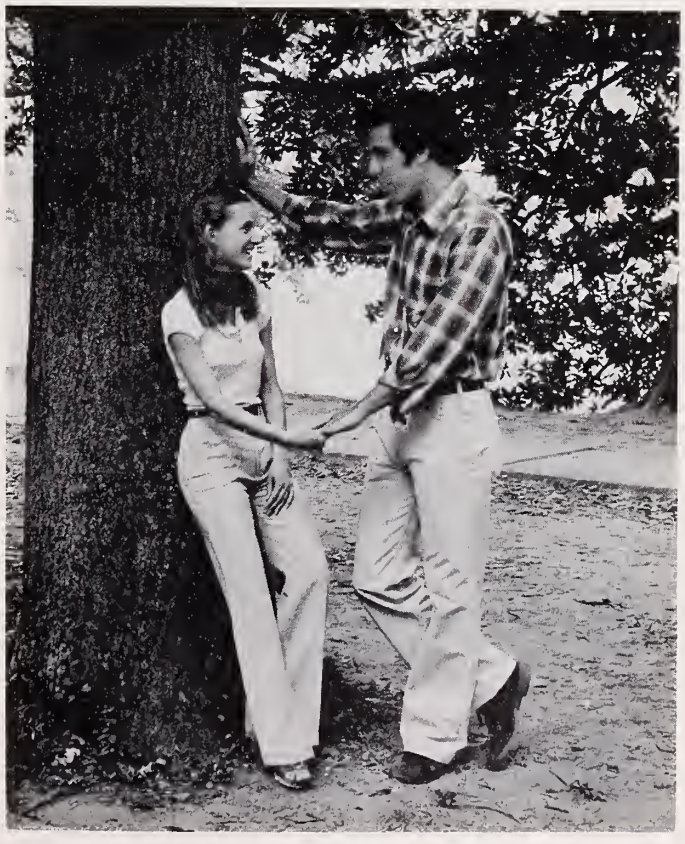
Introduction

TEENAGE PREGNANCY is a major health issue in the United States today. Teenage pregnancies do not occur in a vacuum. They occur in a specific environment. Let us look at the sexual scene in America today. Teenagers are exposed to many destructive influences in the area of sex. The mass media teaches that sex is one way to get ahead. Sex is used to sell products, to produce box office hits, and to sell airplane tickets. Sex is constantly used to sell alcohol and cigarettes. Sexual favors are sometimes used to induce athletes to join a specific college football or basketball team. Sex is repeatedly used and abused by people in offices and businesses throughout the land. In our homes, teenagers see parents who are often mysteriously silent about the sexual mayhem in our society. U.S. teenagers are exposed to the highest divorce rate in the world. It is in the privacy of our own homes that teenagers are afforded the opportunity of having sexual intercourse. This was aptly stated by Margaret Mead:

> They are left alone in the dangerous privacy of homes where both parents are absent. Society only takes an interest in them when society itself is threatened — by teenage pregnancy and teenage venereal disease — when it should be concerned with guarding their health and surrounding their immaturity with supporting institutions.[1]

The messages have been clear to teenagers: sex can be and is used for ulterior purposes; sex can be and is abused; sex is apparently something less than beautiful, or adults would not use it and abuse it as they do. In many ways, the sexual scene in America is very chaotic and frightening.

So it is not surprising that teenagers are asking, "Why can't we use and abuse sex? Everyone else does." In fact, teenagers today do use and abuse sex, and every year more and more individuals in our society spend significant amounts of their time



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FACTS ABOUT TEENAGE PREGNANCY

* **More than 1 million (10%) U.S. teenagers aged 15-19 become pregnant, and 6% give birth. Moreover, some 30,000 girls under the age of 15 also become pregnant.**
* **11 million U.S. teenage boys and girls are sexually active. Only 1 million teenagers are enrolled in family planning clinics.**
* **About ⅓ of all abortions in the United States each year are obtained by teenagers.**
* **Two-thirds of all teenage pregnancies and one-half of all teenage births are unintended.**
* **Georgia has the 3rd highest teenage pregnancy rate in the United States.**
* **One out of every 12 teenage girls aged 15-19 in Georgia has a baby each year.**
* **One out of every 10 babies born to Georgia teens is premature.**
* **In Georgia, as elsewhere, most pregnant teenage girls drop out of school, and pregnancy is the most common reason girls give for dropping out of school.**[1-2]

helping these young people who get hurt and broken because of their own mistakes or the mistakes of another.

To a large extent, the teenage pregnancy problem is an environmental problem. The sexual environment nuturing U.S. teenagers is polluted and is undergirded by the extraordinarily powerful forces of the mass media in our society. So in thinking about a solution to the teenage pregnancy problem, we must avoid looking for any straightforward solution. There is no simple answer to this very complex problem.

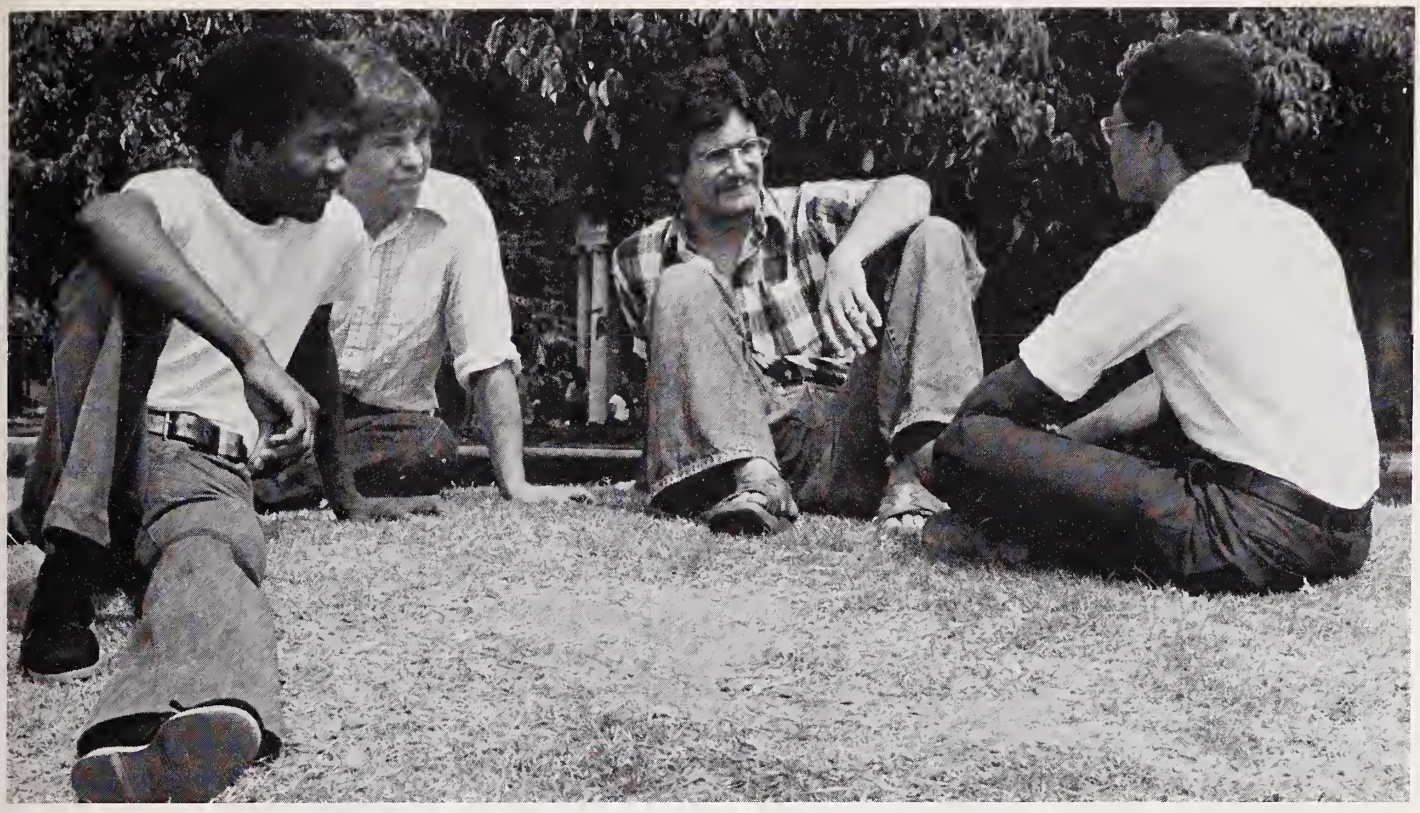
This paper will briefly discuss some of the intricacies of providing specific means of birth control to teenagers. While the authors are convinced that contraception alone will never solve the teenage pregnancy epidemic, contraceptives are an important part of the minimization of this problem.

Teenagers and Specific Birth Control Methods

Recently, the delivery of contraceptive information and services to teenagers has received a great deal of attention.[2, 3-5] The provision and choice of our modern contraceptives may vary according to the age groups, parity, future childbearing plans, and individual preferences of the individual patient. The provider of contraceptives must also be sensitive to the patient's partner, as contraceptive effectiveness is often directly related to the ability of a couple to cooperate in the use of a method of birth control.

When providing contraceptive services to teenagers, several general facts should be kept in mind:

1. Most sexually active teenagers have intercourse infrequently (0, 1, or 2 times per month).
2. Teenagers may go months or years between acts of intercourse. However, once they become sexually active, most teenagers will continue to have sexual intercourse periodically, even if they have been hurt (e.g., with an unplanned pregnancy) and adamantly state that they will never have sex again until they are married.
3. Sexually transmissible infections occur more frequently among teenagers.
4. Each year, 32,000-94,000 U.S. women become sterile as a result of pelvic inflammatory disease.[6]
5. Most teenagers do plan to bear children at some time in the future.
6. Teenagers are interested in knowing if they are fertile. They may develop fears that they are infertile after just one or two unprotected acts of intercourse.
7. Teenagers tend to be careless about using contraceptives and often find it difficult to return for appointments.
8. Teenagers usually have one sexual partner at a time, but over a period of 2-5 years, they may have several sexual partners.
9. Some teenage girls who are having sexual intercourse do not enjoy it and feel that it *is* wrong for them.
10. Teenage contraceptors may not have the support of their parents.
11. Teenage couples may have great difficulty communicating effectively about the choice and use of an appropriate contraceptive.
12. Many teenagers coming to a family planning clinic have a strong need for personalized attention and love. The success of a given contraceptive is going to be more a function of patient



Rap sessions help teenagers learn about their feelings as well as their bodies.

compliance engendered by thoughtful counseling than of the inherent characteristics of the specific contraceptive chosen.

These are several of the factors which should be considered when providing contraceptive services to teenagers. The following remarks about each of the approaches to birth control make no attempt to be comprehensive, but provide a brief outline of some of the considerations to bear in mind when counseling teenagers about each contraceptive approach.

Abstinence

Abstinence is the contraceptive most commonly used by teenagers. Family planning staff and all individuals working with teenagers should validate or support those teenagers who have chosen *not* to be sexually active.

Some teenagers do not want to have sexual intercourse until they are married. Teenagers should be encouraged to look at their values about pre-marital sexual activity. Supportive counseling, including concepts such as "how to say no," should be available for those teens who do not want to have a sexual relationship. Teenage girls and boys should be made aware of factors which contribute to the likelihood of sexual intercourse, including the effect of peer pressure, partner's expectations, and the length of the relationship.

Condoms

Condoms are probably the best contraceptive for teenagers. They are safe and effective *if* used consistently and correctly, and they are the best method for preventing sexually transmissible infections. In our country, 32,000-94,000 women become sterile annually because of tubal occlusion caused by pelvic inflammatory disease.[6] Teenagers should be taught that penicillin has not eliminated sexually transmitted infections.

Most teenagers, however, do not consider condoms as an attractive contraceptive option. Even if a couple will not depend primarily on condoms, they should be encouraged to use condoms at midcycle when ovulation is most likely, when having intercourse with a new partner, during treatment for an infection, or as a back-up means of birth control. Family planners should make every effort to help teenagers become familiar with this method.

If the woman puts the condom on for the man, this may overcome some of the resistance to the interruption of intercourse caused by condoms. In this way, placement of the condom on the penis may be a treat rather than a treatment! Another advantage of the condom is that for a single act of intercourse, condoms are the cheapest method of birth control.

Birth Control Pills

The very high effectiveness of the Pill *if* used correctly, makes them the most popular method among teenagers. "I want birth control" usually means, "I want the Pill."

On the other hand, some teenagers may dislike this method, since it underscores on a daily basis their decision to have sexual intercourse (a decision

they may not feel happy with from a moral or religious standpoint). Young women often discontinue the Pill when a relationship with one boy ends, only to be unprotected when a second relationship begins and leads to sexual intercourse.

All teenagers who use the Pill should also be taught how to use condoms, foam, or a contraceptive suppository, so that one of these non-prescription methods is an option should the Pill be discontinued.

If a person is having sexual intercourse only once a month, is the Pill justified? This question should be carefully considered by each clinician providing the Pill to a girl having infrequent intercourse. Careful, comprehensive counseling is essential when educating teenagers about the risks, benefits, and danger signals of the Pill.

Mini-Pills

The two major disadvantages of the mini-pills (progestin-only pills) for teenagers are the irregular bleeding and anxiety produced in those women who have longer cycles (35 days or more).

The major potential advantages of mini-pills for teenagers are that they produce few if any serious complications and cause less suppression of the hypothalamic-pituitary-ovarian axis than combined (estrogen and progestin) pills.

A clinician concerned about the medico-legal aspects of complications secondary to estrogen-containing pills might feel more comfortable providing mini-pills in view of their greater safety. In addition, it is somewhat easier to explain how to take mini-pills than how to take combined pills. It is essential to stress that a mini-pill user should take her pill every day and that if she misses a pill, she should use a back-up method until her next period starts.

Intrauterine Devices (IUDs)

IUDs are probably the least attractive contraceptive option for sexually active teenagers because of potential infectious complications which may impair a woman's future fertility. A persistent, malodorous vaginal discharge is *not* normal. Of all the IUD danger signals, vaginal discharge is the symptom most often discounted by clinicians and patients alike. Teenagers are particularly likely to underestimate the implications of a vaginal discharge.



Teenagers may be less likely to return should IUD danger signals occur. The IUD danger signals should be taught at the time of IUD insertion and reinforced at each subsequent visit. The Copper-7 should not be used unless the uterus sounds at least 6.5 cm (preferably 7.0 cm).

Foam

When presenting foam as an option to teenagers, its four important advantages should be stressed: (1) it is safe, (2) it is 97% effective, even when used alone, *if* used correctly and consistently,[7] (3) it is available without a physician's prescription and does not require a pelvic examination, and (4) it has some protective effect against sexually transmissable infections. Foam is available in single applications which are smaller and more discreet.

Foamandcondoms is not one word! Either foam or condoms may be used alone as a contraceptive, and either used alone will be about 97% effective *if* used consistently and correctly (Table 1).

Spermicidal Suppositories

Two of the most recent contraceptives in this country are spermicidal suppositories called the Encare Oval and Semicid. Because of their size, Encare Ovals have proven to be easy to transport and insert. For some young people, therefore, somewhat more convenient to carry about and insert than foam or the diaphragm. Another advantage is that contraceptive suppositories do not require a prescription or a pelvic examination.

Diaphragms

Diaphragms are a safe, effective method of birth control which teenagers can be taught to use if one is willing to provide the time, energy, and thoughtful understanding needed to teach their proper use. It is often difficult to fit a woman for a diaphragm if she has never had sexual intercourse. This is particularly true if she has not used tampons during her menstrual period. Using a diaphragm teaches a woman about her own body and may help her feel more comfortable about her sexuality.

Of the coitally-related contraceptives, the diaphragm can be separated most, in terms of time, from the act of intercourse. While it is probably best, vis-a-vis effectiveness, to insert the diaphragm as close to intercourse as possible, a diaphragm may be inserted by a woman prior to a date and then she may safely have intercourse as long as 6 hours later.

Many clinicians find the somewhat more delicate flat spring diaphragm best for nulliparous women.

Natural Family Planning

Young women *and men* should be taught about the menstrual cycle. It can be a fascinating subject. The information can be used effectively by women to avoid or achieve pregnancies and to understand menstrual cycle symptoms for the rest of their lives. Knowledge of the menstrual cycle can help men develop sensitivity regarding an important series of biologic events that women constantly experience.

Withdrawal Method

Withdrawal should be presented as a method of birth control which is less effective than the other approaches but better than no method at all.

The earlier the penis is withdrawn during the act of intercourse, the more effective this approach to birth control can be. Withdrawal requires the cooperation of both partners, and young teenagers may be less likely than older couples to be able to communicate effectively regarding withdrawal.

Sterilization

In general, couples and individuals should be encouraged to wait until their mid-to-late twenties before being sterilized. We who are providing family planning methods may not be taking the irreversibility of sterilization seriously enough. Sterilization should be presented as a permanent and irreversible method. The possibility of return of fertility following vasectomy or tubal ligation should not, at the present time, be presented as an attractive option.

Abortion

One-third of all abortions in the U.S. are performed on teenagers, a percentage which has remained remarkably constant since 1970. Most teenagers are quite concerned about the moral and religious aspects of abortions. Many who feel abortion is wrong or that it represents taking a human life still make the decision to go ahead and have one. Though this decision usually does not produce prolonged psychologic stress, it should be discussed during the counseling prior to an abortion.

A teenager may only be able to call upon abortion once as a backup for carelessness or a contraceptive failure. (A single abortion may be so traumatic that a woman may feel unable to use this approach a second time.) Counseling is extremely important if the need for repeat abortions is to be avoided.

Abortion laws, regulations, and services change rapidly. It is important to have a well-informed individual to whom you can refer patients for the very latest information in your community regarding important factors, such as parental consent, availability of second trimester services, and cost of procedures.

What Should Be Done?

While contraceptives and abortion may be steps toward the minimization of the teenage pregnancy problem, these direct services will never come close to solving the teenage pregnancy problem. Listed below are several interventions which could help a great deal.

I. Improving Services to Teens

A. Staff the clinic with health professionals who enjoy working with teenagers, professionals who will provide sincere and sensitive care.
B. Provide informal educational or "rap" sessions about contraception in which teens can obtain information about options, risks, and benefits. Encourage participation by teens who seek education as well as service.
C. Have a male "rap" leader at teen clinics.
D. Provide support and counseling for teens who choose not to have a sexual relationship.
E. In addition to individual counseling and group sessions, back-up education with written and audio-visual presentations which have been well received and positively evaluated by teens.
F. Talk with teen patients frequently about their needs and obtain their suggestions of ways to improve the clinic. Consider starting a Teen Advisory Board.
G. Staff the clinics with clinicians who will do thoughtful, gentle pelvic examinations. In a healthy teenager seeking contraception, the performance of an examination which is not extraordinarily painful should supercede the desirable end of performing a "complete" examination and obtaining all indicated lab tests.
H. Encourage all family planning staff to follow a caseload of teenagers to provide teens with a specific person to contact for information and follow-up.

II. Community Wide Activities: The "What's Happening" Conference

It is essential that all members of the community become aware that the problem of teenage pregnancy transcends all racial and socio-economic lines. Parents, teachers, ministers, health professionals, and teens must work together to develop new and better strategies. In order to promote such awareness and education, the Department of Gynecology and Obstetrics of the Emory University School of Medicine sponsored the first national health conference for teenagers on sex, birth control, and teenage pregnancy June 19-20, 1978. Over 2,500 teenagers and 500 health professionals and parents from 35 states and Canada participated. The "What's Happening" Conference program emphasized personal

decision-making about sex and other teenage health issues.

Though a major goal was to provide young people with accurate information on birth control, sexually transmitted diseases, pregnancy, and alternatives, the conference planners wanted also to give credence and support to teens who have chosen not to be sexually active. Numerous other health problems were discussed or covered in exhibits, including automobile accidents, nutrition, venereal disease, exercise, and communication with parents. It is often difficult to evaluate the impact such a conference had on its participants. But the following letter sent to us by one teenager describes the type of responsible, independent decision-making the conference and many other similar community-wide sex education programs have tried to encourage:

> I went to your convention this summer. I came from Columbia, South Carolina. At the end of the conference you gave me your card and said to write if I ever had anything important to tell; well I do.
>
> A few nights ago, I went out with this guy I really liked alot, and we went parking. He asked me to have sex with him but I told him no. Thanks to you and your convention. I don't know how I would have handled it. Before the convention I didn't know the odds of getting pregnant but Friday night I remembered. I came home and the first thing I thought about was writing and thanking you.
>
> Also I have a friend who didn't know that much information about sex and birth control so I let her have some of my teen leader papers and it's helped her also. If you ever have another conference in the future, please let me know. I would love to come. I have no criticisms just "Thanks a Million" for caring about us younger adults. Hope to hear from you in the future.
>
> Sincerely,
> Your Friend

In order to assist other groups with the development, implementation, and evaluation of similar conferences, we have compiled the conference proceedings which identifies and discusses every phase of the planning, implementation, and evaluation of the "What's Happening" Conference. It is available at $5.00 per copy from the Emory University Family Planning Program, 69 Butler St., SE, Atlanta, GA 30303.

III. Education and Legislation

We must educate before we legislate. Our elected officials and community leaders must be educated regarding the implications of pregnancies in young teenagers in our society. The authors recommend extensive use of the superb and attractively prepared 64-page booklet by the Alan Guttmacher Institute, *11 Million Teenagers,* as a point of departure for community meetings and efforts to educate elected officials. We also would like to suggest that you obtain copies of *Voices Of Concern: Americans Speak Out for Teenage Health Services*. In this new brochure published by the Emory University Family Planning Program, 23 prominent Americans discuss the serious need for increased teenage health programs. Statements by President Jimmy Carter, Margaret Mead, Hank Aaron, and Senator Edward Kennedy are included. This 17 x 24 inch poster size presentation also includes 10 facts about teenage pregnancy. Free copies are available from the Emory University Family Planning Program, 69 Butler St., SE, Atlanta, GA 30303.

Conclusion

The teenage pregnancy problem is a serious one, and there are no simple straightforward solutions. The medical community must be aware that there are subtleties related to the delivery of each of our modern contraceptives. Moreover, at least as important as the contraceptives themselves is the tone of the clinic or the physician providing these services. Before the teenage pregnancy problem is solved, there must be major societal changes with regard to the use and abuse of sex. The health decisions facing teenagers deserve to be discussed in community-wide meetings held by churches, schools, parents, and a wide range of community organizations.

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ADMINISTRATION AND DOSAGE: One or two tablets three or four times daily before or after meals.

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CONTRAINDICATIONS: **TEGA-VERT** should not be used in patients with known history of sensitivity to any of its ingredients. Because of its vasodilating effects, niacin is contraindicated in the presence of arterial hypotension.

PRECAUTIONS AND SIDE EFFECTS: Although there are not absolute contraindications to oral pentylenetetrazol, it should be used with caution in epileptic patients or those known to have a low convulsive threshold. Dimenhydrinate, like other antihistamines may produce sedative side effects, therefore, caution against operating mechanical equipment should be observed. This has not been a significant problem with **TEGA-VERT** since it contains a mild central nervous system stimulant. Niacin can produce transient flushing and sensations of warmth.

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The risks are significant and well documented.

Effects of Cigarette Smoking During Pregnancy

JOHN J. WITTE, M.D., *Atlanta**

THE PROBLEMS ASSOCIATED with women who smoke cigarettes are assuming greater significance. This is because national surveys indicate that in the last 20 years, increasing numbers of women are starting to smoke. In addition, they are beginning to smoke at an earlier age.[1,2] The effects related to cigarette smoking during pregnancy became known relatively recently. For example, in the original (1964) Report to the Surgeon General on "Smoking and Health," there was only one page (including a bibliography) which summarized a few studies relating low birth weight to smoking during pregnancy.[3]

"You've come a long way, baby" is a sad but true comment on the smoking behavior of women in the United States. Women are now more vulnerable to the well-established smoking-related diseases, which include lung and other cancers, myocardial infarction, bronchitis, and emphysema. In addition, women who smoke during pregnancy expose both themselves and their developing offspring to a variety of health risks.

The risks associated with cigarette smoking during pregnancy include lower-birth-weight infants, increased perinatal mortality, greater incidence of abruptio placentae and placenta previa, and impairment of physical and intellectual development. Many of these untoward effects are reversible, provided the woman stops smoking by the 4th month of pregnancy.

The evidence accumulated to date does *not* support a conclusion that maternal smoking increases the incidence of congenital malformations. However, additional data are needed to document whether or not such as association exists.

Smoking and Birth Weight

There is sufficient evidence to affirm a definite causal association between cigarette smoking and retardation of fetal growth.[4] Generally, babies of smokers[1] weigh 150 to 250 grams less than infants born to women who do not smoke. Women who smoke cigarettes during pregnancy have twice the risk of having an infant that weighs less than 2500 grams. In addition, there is a strong dose-response relationship, with the decrease in birth weight being directly proportional to the number of cigarettes smoked per day. These data are remarkably consistent in studies from many different countries, races, cultures, and geographic settings.

Smoking and Perinatal Mortality

There is a well-established, probably causal, association between cigarette smoking and higher late fetal and infant mortality rates.[4] A number of epidemiologic studies, both prospective and retrospective, demonstrate a statistically significant relationship between cigarette smoking and elevated mortality rates among offspring of women who smoke. A series of articles by Meyer et al.[5-7] analyzed data from the Ontario Perinatal Study of all single births in 10 Ontario teaching hospitals during 1960-61. The study involved a total of 51,490 births, including 701 fetal deaths and 655 early neonatal deaths. The occurrence of perinatal mortality among smoking mothers is greater among those women who already have higher risks for perinatal mortality which are independent of smoking status. These risk factors are related to parity, socioeconomic status, previous pregnancy history, hemoglobin levels, presence of cardiovascular disease, etc. In addition, heavy smokers appear to be at an even greater risk than light smokers. Thus, the risk for increased perinatal mortality associated with light smoking among healthy, young, middle or upper class, low-parity, nonanemic mothers is relatively low (about 10%). In contrast, among women of high parity, low socioeconomic status, with previous low-birth-weight infants, or with hemoglobin levels less than 11 grams, perinatal mortality rates are 70 to 100% higher than those for nonsmokers. Clearly, pregnant

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women who already are at elevated risk should be encouraged and assisted by their clinicians to stop smoking if at all possible.

Other Morbidity During Pregnancy

In addition to the increased perinatal mortality rates among cigarette smokers, there are also increased rates of placenta previa, abruptio placentae, bleeding during pregnancy, and prolonged rupture of the membranes among women who smoke cigarettes.[5-7] These conditions can affect the welfare of the mother as well as that of the infant. The levels of risk for each of these problems are also dose related (i.e., higher risks among heavier smokers). The rates of occurrence for both placenta previa and abruptio placentae are higher for smokers than for nonsmokers at all stages of gestation but appear to be slightly higher in the earlier weeks of pregnancy.

These conditions are probably due to the fact that some components of cigarette smoke are directly related to arterial damage. For example, carbon monoxide (CO) is a major component of cigarette smoke and results in elevated carboxyhemoglobin (COHb) levels in both the mother and fetus. A British study shows that after smoking a single cigarette, pregnant women have greater increases in COHb concentration than nonpregnant women.[8] In addition, the levels of COHb are even higher than maternal levels, regardless of whether or not the mother smokes cigarettes. Studies with animals support the association between significant exposure to CO and arterial damage. This increased exposure to CO in smokers is a likely mechanism of action for these conditions; however, this remains to be documented. Other substances in smoke may also contribute to arterial damage.

Long-Term Effects on Physical and Intellectual Development

Several studies from the United States and Great Britain demonstrate an association between cigarette smoking during pregnancy and impaired physical and intellectual development in the offspring.[9-12] One large study found statistically significant differences in both height and reading ability at 7 and 11 years of age, depending on whether or not mothers smoked during pregnancy.[9]

What Can Be Done

Physicians and other professional persons working with pregnant women who smoke have an obligation to help them stop smoking at least for the duration of their pregnancy. Optimally, doctors should set an example and not smoke. For those physicians who continue to smoke, however (approximately 20%), it is strongly recommended that they not do so in the presence of their patients. Similarly, nurses and other persons employed in physicians' offices, in clinics, and in hospitals should never smoke in patient areas. In fact, smoking should not be permitted for patients or staff persons in these areas.

The use of brochures, posters, and other educational materials in the patient waiting areas is often helpful, as well as informative, and can facilitate the physician-patient dialogue on smoking. Brochures and posters can be obtained from the American Cancer Society, the American Lung Association, the American Heart Association, and the March of Dimes. In addition, kits designed to help the patient with the smoking cessation process are available from the American Cancer Society at a nominal cost. Many pregnant women simply are not aware of the increase in risks as a result of their smoking. They should be made aware of these unique health hazards, both to themselves and to their developing fetus, and they should be urged to quit. Adequate information to make a decision and a professional recommendation toward the proper decision are necessary steps, even if the patient is not able to successfully stop smoking. Many women are concerned about weight gain after quitting. Although some weight gain may follow, this is generally not a major problem for most people.

There are no gimmicks, gadgets, techniques, or approaches that are universally successful to help the smoker quit. For most habituated smokers, tapering off will not facilitate the quitting process. In order to be successful, the smoker needs to make a personal decision and commitment to stop smoking and should set a date to do so. Stopping "cold turkey" is very difficult for most people. Encouragement and reinforcement are often necessary adjuncts during the first few days and weeks after quitting. Such encouragement should come from the patient's family and friends as well as the physician and members of the office staff. During the early days and weeks (after quitting), it is helpful to provide an environment free from smoke and smokers.

Those people not able to quit on their own can be referred to organized smoking cessation clinics. In Georgia, the American Cancer Society and the American Lung Association sponsor group programs free or at a nominal cost. Commercial cessation programs are conducted in Atlanta and other cities in Georgia.* They rely largely on group dynamics, helpful tips from successful "quitters," and a mutual desire to stop smoking. The rates of success of these groups may vary, but they average about 30%, as defined by the proportion of persons who are not smoking 1 year after completion of the program.

* Consult Yellow Pages of telephone book under "Smokers Information and Treatment Center."

Since the consequences of smoking in pregnancy are all dose related, those persons who are unable or unwilling to stop entirely should be advised to reduce their dose. This can be accomplished in the following ways: (1) smoke fewer cigarettes each day, (2) select a low "tar" and nicotine brand,† (3) take fewer puffs of each cigarette smoked, and (4) do not inhale each puff as deeply. There are commercial devices on the market (for example, Water-Pik) designed to reduce the level of "tar" and nicotine; however, any advertised claims toward facilitated cessation of smoking are not substantiated by proven facts.

In summary, the risks of smoking during pregnancy are significant and well documented. Physicians are obliged to educate their patients about these risks and do whatever they can to aid them in quitting.

† Lower "tar" and nicotine brands frequently have lower CO levels as well. Later in the year, the Federal Trade Commission plans to begin to publish CO levels for each brand. Obviously, a brand with as low a CO level as possible should be selected.

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Tenuate®
(diethylpropion hydrochloride NF)

Tenuate Dospan®
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AVAILABLE ONLY ON PRESCRIPTION
Brief Summary
INDICATION: Tenuate and Tenuate Dospan are indicated in the management of exogenous obesity as a short-term adjunct (a few weeks) in a regimen of weight reduction based on caloric restriction. The limited usefulness of agents of this class should be measured against possible risk factors inherent in their use such as those described below.
CONTRAINDICATIONS: Advanced arteriosclerosis, hyperthyroidism, known hypersensitivity, or idiosyncrasy to the sympathomimetic amines, glaucoma. Agitated states. Patients with a history of drug abuse. During or within 14 days following the administration of monoamine oxidase inhibitors, (hypertensive crises may result).
WARNINGS: If tolerance develops, the recommended dose should not be exceeded in an attempt to increase the effect; rather, the drug should be discontinued. Tenuate may impair the ability of the patient to engage in potentially hazardous activities such as operating machinery or driving a motor vehicle; the patient should therefore be cautioned accordingly. *Drug Dependence:* Tenuate has some chemical and pharmacologic similarities to the amphetamines and other related stimulant drugs that have been extensively abused. There have been reports of subjects becoming psychologically dependent on diethylpropion. The possibility of abuse should be kept in mind when evaluating the desirability of including a drug as part of a weight reduction program. Abuse of amphetamines and related drugs may be associated with varying degrees of psychologic dependence and social dysfunction which, in the case of certain drugs, may be severe. There are reports of patients who have increased the dosage to many times that recommended. Abrupt cessation following prolonged high dosage administration results in extreme fatigue and mental depression; changes are also noted on the sleep EEG. Manifestations of chronic intoxication with anorectic drugs include severe dermatoses, marked insomnia, irritability, hyperactivity, and personality changes. The most severe manifestation of chronic intoxications is psychosis, often clinically indistinguishable from schizophrenia. *Use in Pregnancy:* Although rat and human reproductive studies have not indicated adverse effects, the use of Tenuate by women who are pregnant or may become pregnant requires that the potential benefits be weighed against the potential risks. *Use in Children:* Tenuate is not recommended for use in children under 12 years of age.
PRECAUTIONS: Caution is to be exercised in prescribing Tenuate for patients with hypertension or with symptomatic cardiovascular disease, including arrhythmias. Tenuate should not be administered to patients with severe hypertension. Insulin requirements in diabetes mellitus may be altered in association with the use of Tenuate and the concomitant dietary regimen. Tenuate may decrease the hypotensive effect of guanethidine. The least amount feasible should be prescribed or dispensed at one time in order to minimize the possibility of overdosage. Reports suggest that Tenuate may increase convulsions in some epileptics. Therefore, epileptics receiving Tenuate should be carefully monitored. Titration of dose or discontinuance of Tenuate may be necessary.
ADVERSE REACTIONS: *Cardiovascular:* Palpitation, tachycardia, elevation of blood pressure, precordial pain, arrhythmia. One published report described T-wave changes in the ECG of a healthy young male after ingestion of diethylpropion hydrochloride. *Central Nervous System:* Overstimulation, nervousness, restlessness, dizziness, jitteriness, insomnia, anxiety, euphoria, depression, dysphoria, tremor, dyskinesia, mydriasis, drowsiness, malaise, headache; rarely psychotic episodes at recommended doses. In a few epileptics an increase in convulsive episodes has been reported. *Gastrointestinal:* Dryness of the mouth, unpleasant taste, nausea, vomiting, abdominal discomfort, diarrhea, constipation, other gastrointestinal disturbances. *Allergic:* Urticaria, rash, ecchymosis, erythema. *Endocrine:* Impotence, changes in libido, gynecomastia, menstrual upset. *Hematopoietic System:* Bone marrow depression, agranulocytosis, leukopenia. *Miscellaneous:* A variety of miscellaneous adverse reactions has been reported by physicians. These include complaints such as dyspnea, hair loss, muscle pain, dysuria, increased sweating, and polyuria.
DOSAGE AND ADMINISTRATION: Tenuate (diethylpropion hydrochloride): One 25 mg. tablet three times daily, one hour before meals, and in midevening if desired to overcome night hunger. Tenuate Dospan (diethylpropion hydrochloride) controlled-release: One 75 mg. tablet daily, swallowed whole, in midmorning. Tenuate is not recommended for use in children under 12 years of age.
OVERDOSAGE: Manifestations of acute overdosage include restlessness, tremor, hyperreflexia, rapid respiration, confusion, assaultiveness, hallucinations, panic states. Fatigue and depression usually follow the central stimulation. Cardiovascular effects include arrhythmias, hypertension or hypotension and circulatory collapse. Gastrointestinal symptoms include nausea, vomiting, diarrhea, and abdominal cramps. Overdose of pharmacologically similar compounds has resulted in fatal poisoning, usually terminating in convulsions and coma. Management of acute Tenuate intoxication is largely symptomatic and includes lavage and sedation with a barbiturate. Experience with hemodialysis or peritoneal dialysis is inadequate to permit recommendation in this regard. Intravenous phentolamine (Regitine®) has been suggested on pharmacologic grounds for possible acute, severe hypertension, if this complicates Tenuate overdosage.

Product Information as of April, 1976

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MERRELL-NATIONAL LABORATORIES
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75 mg. controlled-release tablets



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Overweight patients in certain diagnostic categories often require strict obesity control. Diethylpropion hydrochloride has been reported useful in obese patients with hypertension, symptomatic cardiovascular disease, or diabetes. While it is not suggested that Tenuate in any way reduces these complications in the overweight, it may have a useful place as a short-term adjunct in a prescribed dietary regimen. (Tenuate should not be administered to patients with severe hypertension; see additional Warnings and Precautions on the opposite page.)

In uncomplicated obesity.

Many patients, on the other hand, present with excess fat but no disease. While this condition is often termed uncomplicated obesity, complications of both a social and a psychologic nature may be distressingly real for the patients. In these cases, a short-term regimen of Tenuate can help reinforce your dietary counsel during the important early weeks of an indicated weight loss program.

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April 197

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Makes Sense

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In Hypertension

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Serum K^+ and BUN should be checked periodically particularly in the elderly, diabetics, and those with suspected or confirmed renal insufficiency (see Warnings). If hyperkalemia develops, substitute a thiazide alone.



Before prescribing, see complete prescribing information in SK&F Co. literature or *PDR*. A brief summary follows:

* **WARNING**
This drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual. If this combination represents the dosage so determined, its use may be more convenient in patient management. Treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

Contraindications: Further use in anuria, progressive renal or hepatic dysfunction, hyperkalemia. Pre-existing elevated serum potassium. Hypersensitivity to either component or other sulfonamide-derived drugs.

Warnings: Do not use potassium supplements, dietary or otherwise, unless hypokalemia develops or dietary intake of potassium is markedly impaired. If supplementary potassium is needed, potassium tablets should not be used. Hyperkalemia can occur, and has been associated with cardiac irregularities. It is more likely in the severely ill, with urine volume less than one liter/day, the elderly and diabetics with suspected or confirmed renal insufficiency. Periodically, serum K^+ levels should be determined. If hyperkalemia develops, substitute a thiazide alone, restrict K^+ intake. **Associated widened QRS complex or arrhythmia requires prompt additional therapy.** Thiazides cross the placental barrier and appear in cord blood. Use in pregnancy requires weighing anticipated benefits against possible hazards, including fetal or neonatal jaundice, thrombocytopenia, other adverse reactions seen in adults. Thiazides appear and triamterene may appear in breast milk. If their use is essential, the patient should stop nursing. Adequate information on use in children is not available.

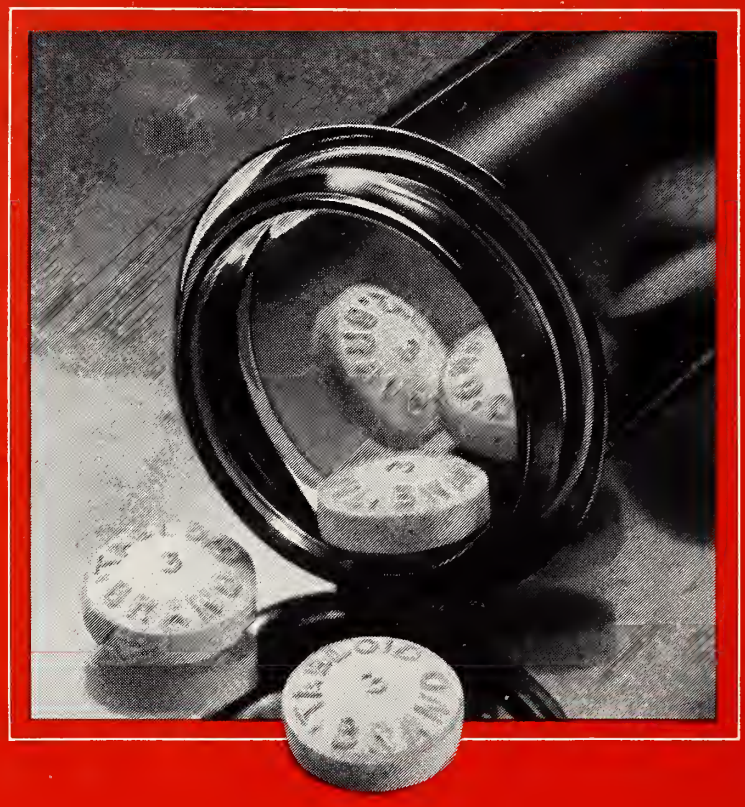
Precautions: Do periodic serum electrolyte determinations (particularly important in patients vomiting excessively or receiving parenteral fluids). Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics or those with suspected or confirmed renal insufficiency. Watch for signs of impending coma in severe liver disease. If spironolactone is used concomitantly, determine serum K^+ frequently; both can cause K^+ retention and elevated serum K^+. Two deaths have been reported with such concomitant therapy (in one, recommended dosage was exceeded, in the other serum electrolytes were not properly monitored). Observe regularly for possible blood dyscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving triamterene, and leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with thiazides. Triamterene is a weak folic acid antagonist. Do periodic blood studies in cirrhotics with splenomegaly. Antihypertensive effect may be enhanced in postsympathectomy patients. Use cautiously in surgical patients. The following may occur: transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), hyperuricemia and gout, digitalis intoxication (in hypokalemia), decreasing alkali reserve with possible metabolic acidosis. 'Dyazide' interferes with fluorescent measurement of quinidine.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis, rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting, diarrhea, constipation, other gastrointestinal disturbances. Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and, rarely, allergic pneumonitis have occurred with thiazides alone.

Supplied: Bottles of 100 and 1000 capsules; Single Unit Packages of 100 (intended for institutional use only).

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This odious crime continues to plague our society.

Child Abuse in Georgia, 1975-1977*



SIXTY-TWO PERCENT of child abusers in Georgia in the 2-year period from July 1975 to July 1977 were natural parents, according to a recent study by the Georgia Department of Human Resources. The report, which examined the social and demographic characteristics of abused children, their families, and the abusers in the state, also found that natural mothers who abused their children were more likely than other mothers to have begun childbearing in their teenage years, and that children born out-of-wedlock were 2.5 times more likely to be abused than children born in wedlock.

The study was based on reports received by the Child Abuse Registry and reviewed by the local county child protective worker. Of 2,281 cases reported, 1,319 (58%) reports were verified as cases of physical or sexual abuse. A confirmed case was one in which the local county worker determined that sufficient evidence had been obtained to confirm the abuse. Cases of neglect were not included, and no assessment of completeness of reporting was made.

Almost half (48%) of the reports of possible abuse were made by three sources: medical clinics, school officials, and concerned citizens. Private physicians and public health officials were not a common source of referral; together they reported only 5% of the cases. Those who reported a case that was subsequently confirmed were most likely to be school officials, the police, and juvenile courts. Those reports made by citizens and relatives were the least likely to be subsequently confirmed as actual abuse cases.

The Abused Child

Almost 20% of the confirmed cases had a history of being previously abused, and the children with a previous history of abuse were more likely than others to have the current report of abuse confirmed. Court action was taken to protect the child in 23% of the cases. For all age groups, rates in urban areas were at least 1.3 times higher than rates in rural areas; for urban 15- to 18-year-old youths the rate of abuse was 2.5 times higher.

Abuse rates were higher for females than for males in both urban and rural areas. Fifty-four percent of the confirmed cases were females. The highest male

* Reprinted with permission from the Center for Disease Control's *Morbidity and Mortality Weekly Report*, Vol. 28, No. 3.

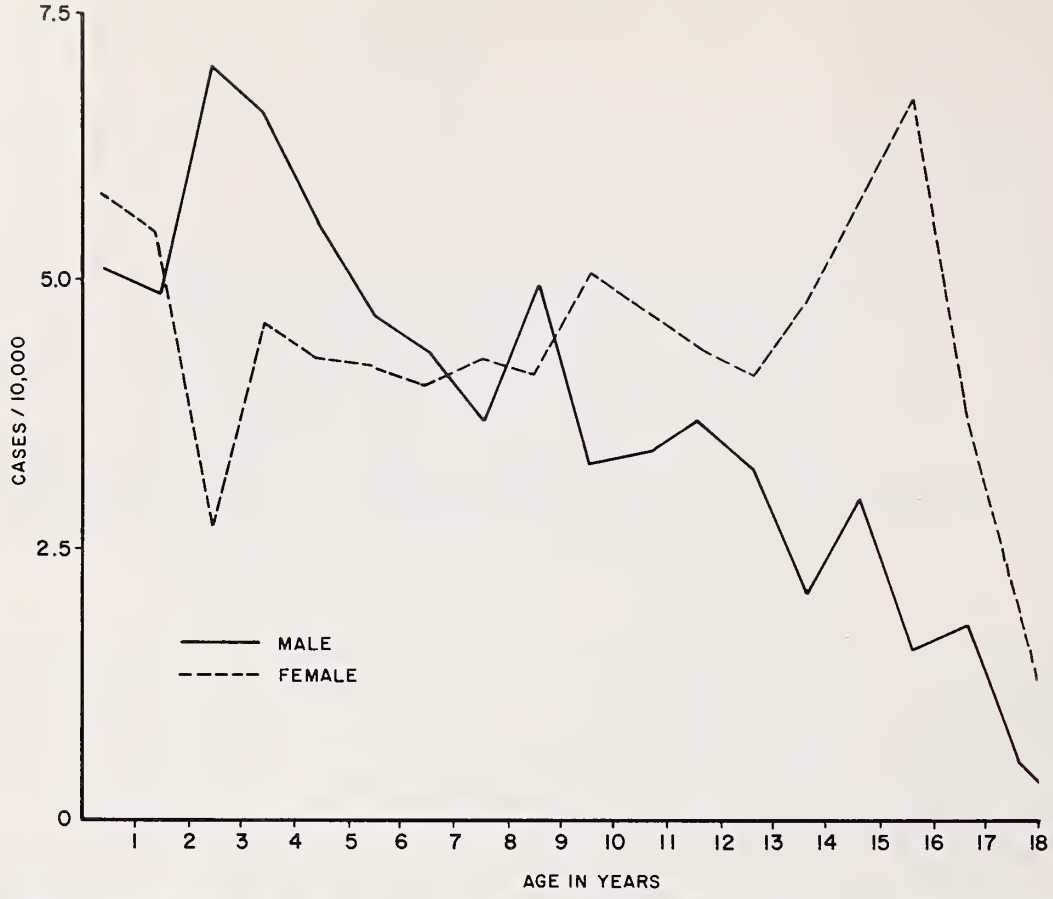


Figure 1 — Confirmed child abuse rate, by age, male and female children, Georgia, July 1975-June 1977.

rate (7.2/10,000) was seen in the 2- to 3-year-old age group, and the highest female rate (7.0/10,000) was in those 15-16 years old (Figure 1).

Bruises were the most commonly sustained injuries, although 22% of all cases had multiple injuries. In 14.3% of all confirmed cases, the child had been sexually abused. With females, sexual abuse was more common, representing 23.8% of all confirmed female abuse cases. For boys, there was a higher rate of burns, abrasions, skull fractures, brain damage, malnutrition, and multiple injuries. The mean age of the sexually abused child was 10 years; almost 90% were girls. Twenty-six children died following abuse. The death-to-case ratio was 20 per 1,000, and the 0- to 4-year-old age group had a significantly higher death-to-case ratio than any other age group.

The Family of the Abused Child

Both natural parents were living in the household in 39% of the instances in which a confirmed case of child abuse occurred (Table 1). The natural mother was the only caretaker present in 26% of the cases; by contrast, the natural father was the sole caretaker in only 2.5% of the cases. The mean age of the natural father, when living in the home at the time of the abuse, was 33 years; the mean age of the natural mother, when present, was 28 years. The abused child was the only child in the family in 23% of the cases, while one to two other children were present in 50% of the cases, and more than two other children were there in the remaining instances.

TABLE I
HOUSEHOLD COMPOSITION OF CONFIRMED CHILD ABUSE CASES, GEORGIA, JULY 1975 - JUNE 1977

Composition	Number	Percent
Both natural parents	511	38.7
Natural mother only	337	25.5
Natural mother — stepfather	217	16.5
Stepmother — natural father	50	3.8
Natural mother — substitute father	49	3.7
Natural father only	33	2.5
Other	122	9.3
Total	1,319	100.0

To determine if the abuse of younger children is associated with, or predicted by, events identifiable before or at the time of birth, the reports of confirmed abused children less than 4 years of age were linked with these children's Georgia birth certificates. (This age was chosen because new birth certificates containing detailed medical histories were adopted in 1973.) Linkage was accomplished in 75% of the 326 cases.**

** The only significant difference between linked abused children and unlinked abused children was that the ability to link records was inversely related to the age of the child. This may be due to the greater likelihood that older children were born in another state.

Three perinatal characteristics — marital status, complications related to pregnancy and delivery, and birth weight — were examined for the children in the study and compared with the birth certificate data for all children born in Georgia in 1976. The only significant association with subsequent child abuse was out-of-wedlock births ($p < .05$). Although the rates of complications and of low birth weight were higher in the abused children, they were not statistically significant.

The Child Abusers

The mean age of all child abusers was 30; 58% were males. Sixty-two percent of the child abusers were the natural parents. Half were mothers; their most common age, 20-24 years. Of the 50% of abusers who were fathers, 40-44 years was the most common age range. Fifty-three percent of all natural mothers who were child abusers had had a live birth in their teenage years, whereas in Georgia approximately one-third of all natural mothers have had an adolescent pregnancy.

In cases of sexual abuse, 35% of the abusers were the natural fathers. In 68% of the cases of sexual abuse, there was a previous history of some type of abuse.

Editorial Note: The ability to draw inferences about differences in child abuse rates depends upon the completeness of reporting and upon the bias introduced by reporting practices. The determination of abuse may be influenced by such characteristics as past history of suspected abuse; social, economic, and cultural differences between the investigator and those investigated; and the frequency and intensity of the family's contact with a social service agency.[1] This registry does not include negligence, a more common event. The extent to which certain segments of a population may be either reported more frequently or subject to those stresses or behavior patterns which can lead to child abuse was not evaluated in this study.

Child abuse in the United States first received national recognition in 1946 when Caffey, a specialist in pediatric radiology, discussed several cases involving multiple fractures of infants in various stages of healing.[2] Kempe coined the term "the battered child" in a 1962 article, in which he presented findings of reported incidents of abuse from 71 hospitals and 77 district attorneys representing the entire United States.[3]

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The special responsibilities of obstetrician-gynecologists are discussed along with their current involvement in the area of teen pregnancy.

Teenage Pregnancy — A Liability to Our Future

ALTON V. HALLUM JR., M.D., *Atlanta**

MANY STUDIES have outlined the magnitude of the problem of teenage pregnancy that stretches across our country and touches every socioeconomic level. Georgia ranks 49th out of the 51 reporting districts with the highest percentage of teenage pregnancies. The economic and social impact of the subsequent liability created will affect the future of our state in many ways:

1. Adolescent pregnancy involves greater health risks, including an increased incidence of prematurity, toxemia, anemia, perinatal mortality, and neurologic defects in the offspring.
2. Most teenage mothers drop out of school and neither finish their education nor realize the dreams they had for their future. If the couple marries, then two educations are interrupted short of their potential, probably never to be realized because of the responsibility of providing for a child. Well over three-fourths of these marriages end in divorce within 6 years.
3. Nine out of 10 single women keep their babies, often struggling to raise them at below-poverty incomes. The risk of child abuse and suicide by teenage mothers is also higher.
4. Psychologic and developmental problems are more common in these young parents. Their problems are then passed on to the children who learn by patterning themselves after their parent(s). The attitude of being "left behind" or "failing to achieve" is engendered.
5. Additional pregnancies are common, and these also carry a higher risk to the mother and her offspring.

All of these factors adversely affect our society, both as added financial burdens and as sociologic burdens resulting from the failure of teenagers to reach their intellectual potential.

Several studies have shown that with "intensive care teenage pregnancy services" the medical and emotional problems can be markedly reduced. Equally important is the result of larger numbers of these patients who return to and finish high school, as well as those who contracept effectively to prevent additional unplanned pregnancies. This approach is helpful to the pregnant teenager and should be continued. But why wait until the teenager is pregnant to offer her the vast resources of our society?

"Adolescent pregnancy involves . . . an increased incidence of prematurity, toxemia, anemia, perinatal mortality, and neurologic defects in the offspring."

The majority of teenage pregnancies are unplanned and often unwanted. At least one-third of these women have abortions. Some of the remaining wait too long to get help in the first trimester, while others cannot raise the money for a therapeutic abortion. A more effective approach might be public school education on sexual responsibility and contraception.

Many organizations, groups, and individuals have made independent efforts to deliver these services. The results have been good but spotty. In 1978, the problem of teenage pregnancy prevention was the focus of a joint project coordinated by the Georgia Department of Human Resources. Several agencies had been trying to work toward this goal indepen-

* Dr. Hallum is an obstetrician-gynecologist and Chairman of the Georgia OB-GYN Committee on Prevention of Teenage Pregnancy. His address is 35 Collier Rd., NW, Suite 320, Atlanta, GA 30309.

dently, often without being aware of what others were doing.

An ad hoc committee was created in 1978 by the State Department of Physical Health under the guidance of Dr. James W. Alley. A task force consisting of representatives from various state agencies was organized in each of the 19 state health districts. This allowed pooling of resources to do a better job. Members have been appointed, and some of these tasks forces are already working locally.

The obstetrician-gynecologist is the physician who must step forward to meet this problem. We daily counsel women regarding contraception and family planning. For most healthy women in the child-bearing years, we are the only physician they see. We are the primary care physicians for this group and must deal with all the aspects of health

"Open-forum discussions would allow all parents to share this information [re: sex and reproduction] and help their children grow up informed, with an open, relaxed attitude about sex."

care. The earlier age of menarche means even younger women are capable of having problems related to menstrual bleeding or pregnancy exposure. Most of these women move from the pediatrician's office to our care. Many more choose our services because they know most of their needs for the next 20-30 years will come under our expertise anyway. We are the physicians who counsel them regarding family planning, vaginal diseases, pregnancy, irregular bleeding, and infertility. In the age of specializations, fewer family practitioners and internal medicine specialists feel comfortable in these areas. This is our speciality, and we must accept this responsibility for our communities.

As community members, we must make ourselves available to educate the parents of adolescents and teenagers regarding sexuality and reproductive physiology. Open-forum discussions would allow all parents to share this information and help their children grow up informed, with an open, relaxed attitude about sex. The best hope will be a comprehensive teaching effort supported by schools, churches, health agencies, and media that includes students AND parents. If the parents have access to the same information, then the family will remain the center to discuss the incorporation of this into their existing value systems.

The obstetrician-gynecologist has a responsibility to the teenage patient that is a little different. It requires more time on our part for which we may not receive financial reimbursement. These young women are anxious, afraid, unsure, and embarrassed when they come into our office. They are often afraid that we will tell their parents about the facts surrounding their seeking our help. They fear being treated as children and lectured at judgmentally. On the contrary, we should deal with them as we would any older patient and perhaps with even greater care.

"The obstetrician-gynecologist has a responsibility to the teenage patient that is a little different."

They often need the caring attention of an adult other than their parent. We must help young people learn basic reproductive facts before they become sexually active. Moreover, we must support them if they choose not to become sexually active. If they do plan to be sexually active, they must be aware of the consequences and accept the responsibility of their actions.

As physicians with a vested interest in our community, we must educate adults and especially community leaders about the seriousness of this problem. We must stress a need for action and reach out to involve others in dealing with this problem. We will have it with us as long as we have pubescent teenagers. Therefore, the community efforts will have to be ongoing and available to each maturing group of teenagers and parents.

In December 1977, the Georgia State Obstetrics and Gynecologic Society declared the increasing rate of teenage pregnancy to be the number one problem in the state. A committee has been active for over 1 year trying to find out what groups have been actively working to correct this trend, plus stimulating awareness of the problem to any potential resource group. Members of our society have been active for years as participants in local school, church, and youth programs dealing with sexuality and decision making. Individual physicians have volunteered to become members of the 19 task forces across the

"We must stress a need for action and reach out to involve others in dealing with this problem."

state. We have the expertise needed to provide information and educate all other interested people on the task forces. We would be the physicians to perform any physical examinations needed. Locally, our members have personal friendships with administrators, social leaders, and state officials to more expeditiously obtain their support. In this capacity, we can stimulate action and, more importantly, keep the programs working effectively.

Media interest goes in cycles, and the emphasis

shifts periodically to other social problems, for example, nutrition, drugs, alcohol, cigarette smoking, etc. Our society needs to take the lead in continuing to educate and inform teachers, counselors, and community leaders about the problem of teenage pregnancy. A sound program of sex education should be maintained in each local community and updated as new information dictates.

The 19 district task forces are now operational. Our committee feels a central coordinating office needs to be created and funded. Its function would be to gather and disseminate new statistics and successful teaching programs. It would be the central contact for any local group to obtain the latest information or find out about state resources. The office would also publish a newsletter to be mailed throughout the state to keep all communities informed on what programs the other health districts are using. There would be evaluations of successful teaching tools and critiques of the programs that were not felt to be effective. The latest community, state, and national statistics would be shared. Announcements of training programs and resource people would be made so that all the community programs could be shared and coordinated. This office would also be the main instrument to keep all the health districts active, supporting those that failed to keep abreast, as well as volunteering help for any of those in need. Funds to support this central coordinating office have not yet been found, but several avenues are being explored.

"Our committee feels a central coordinating office needs to be created and funded . . . to gather and disseminate new statistics and successful teaching programs."

In addition to sex education information, the family planning clinics will have to upgrade the facilities to provide age-appropriate services to discuss the alternatives available for contraception. Group discussions might be helpful to share anxieties and offer support especially for those who choose NOT to become sexually active. This expanded network of family planning counselors would be expensive.

To obtain increased funds would mean educating the legislators and elected local officials to the needs for increased support, personally and monetarily, to make these facilities work.

We must make available early pregnancy testing and counseling to all teenagers to confirm pregnancy and discuss the alternatives. Safe, legal abortions must be accessible and affordable.

In addition to teenage pregnancy clinics, we must provide adequate educational, social, and employment services to adolescent parents, especially day-care facilities for their babies to allow them to complete their education.

The problem of teenage pregnancy will not go away for many of the same reasons unwanted pregnancies still occur in the adult female population. But it is the teenagers who are prevented from realizing their potential if pregnancy cuts short their formal education.

Many federal governments, such as Sweden, support educational and service programs of contraception for teenagers and advertise that every child should be wanted. Sex education is mandatory in schools and accessible contraception clinics have been developed. We encourage the support of the family in obtaining the same information and discussing the value systems in light of the alternatives available.

The apparent epidemic of teenage pregnancies represents one of the most serious impediments to full physical, mental, and educational development of our younger generations. Only through mass education and full involvement of all of our resources can we curb this trend. We have an obligation both to our ancestors and to future generations to eradicate this pattern of lost educational opportunity, unstable family life, poor employability, and welfare dependence.



The trained nurse has become one of the great blessings of humanity, taking a place beside the physician and the priest, and not inferior to either in her mission.

Sir William Osler (1849-1919): *Aequanimitas, With Other Addresses,* "Nurse and Patient"



president's letter

Fundamentals — Better Patient Care

AFTER A PROFESSIONAL, college, or high school football game defeat, the coach often says, "Today we're going to practice the fundamentals of football — blocking and tackling."

You will agree that organized medicine has had some recent defeats. I recommend to you that we start today practicing a fundamental of medicine — better patient care.

We may get beat in the courts, the state legislature, and the U.S. Congress, but we can always win on our own home field — our offices and hospitals — *IF* we will treat our patients as we would like to be treated when we are patients.

Let's get back to the fundamentals of the practice of medicine today by applying this simple Golden Rule.

Earnest C. Atkins

Earnest C. Atkins, M.D.
President, MAG

editorial
editorial
editorial

Teenage Pregnancy—Another Look

THIS ISSUE of the *Journal* features discussions of the many well-staffed programs designed to provide education, counseling, and in some cases, contraceptives, to teenagers in our state. Georgia has the third highest teenage pregnancy rate in the country, so it is good that our social agencies are addressing themselves to this problem.

Yet I believe that another look at this problem is mandatory, because I believe that these programs are insufficient to successfully handle their appointed task, namely, to effect a significant reduction in the rate of teenage pregnancy in our state.

I believe this for several reasons. One is because national efforts that are similarly designed in their approach to this problem have failed to effect a reduction in the rate of teenage pregnancy. In fact, just the opposite has occurred. Consider the following facts:

In the past 5 years, family planning agencies have reached more teenagers than ever before. Between 1970 and 1975, the number of teenagers in organized family planning programs quadrupled.[1] Abortion became legal and widely available to teenagers. Instruction in the use of contraceptives became a normal (even though unofficial) part of the curriculum in sex education courses across the country. It would seem reasonable, then, to expect a decline in teenage pregnancy during this period. The finds of Kantner and Zelnik, however, reveal just the opposite trend.

In their 1971 study,[2] 6.4% of the girls interviewed had had a premarital pregnancy. By 1976, this number had risen to 9.3%, an increase of 45%. This was related to a nearly equal increase (41%) in the percentage of girls who had had premarital intercourse, from 26.3% in 1971 to 37.2% in 1976.[3] The rate of out-of-wedlock births, in spite of the legalization and widespread use of abortion, increased from 10.3 per 1000 in 1971 to 12.1 per 1000 in 1975, up 18%.[4]

Changes in contraceptive practices were also significant during this 5-year study period.[5] In 1971, only 19.7% of the girls contracepted every time they had intercourse. By 1976, this number had grown to 30.2%.[6] Perhaps more significant, fewer than half the girls in the 1971 sample (45.1%) had used a contraceptive during their last sexual encounter before they were interviewed. In 1976, almost two thirds (64.8%) had.[6] In 1971, only 13.8% of the sexually active girls were using birth control pills or intrauterine devices. This percentage more than doubled by 1976 to 33.3%.[7] Zelnik and Kantner had good reason for expressing surprise at their "lack of decline" in teenage pregnancy. This "lack of decline" is actually an increase.

The effectiveness of contraception for teenagers is something that has been well known at least since 1973. When Ryder[8] published his study showing that the failure rate among young women using oral contraceptives was four to five times higher than that among older women, and when this fact is considered in conjunction with an earlier study by Ryder and Westoff,[9] showing that even older married women are none too successful in preventing unintended conceptions, the situation appears even worse.

There are some who look upon contraceptive programs for teenagers as an alternative to abortion. Kantner and Zelnik inadvertently show how illusory is the hope of reducing the so-called "need" for abortion by giving teenagers contraceptives. They compared the percentage of contraceptive users among those girls who obtained an abortion with the percentage of contraceptive users among those with some other pregnancy outcome and found that those girls having abortions were almost twice as likely to have been contracepting at the time pregnancy occurred.[10] In other words, girls who became pregnant while using a contraceptive were more likely to seek an abortion than were those who became pregnant without using a contraceptive.

". . . poor parenting [is] a primary cause of our present dilemma."

Perhaps Kingsley Davis summed it up most succinctly in his report to the United States Commission on Population Growth and the American Future:

> The current belief that illegitimacy will be reduced if teenage girls are given effective contraceptives is an extension of the same reasoning that created the problem in the first place. It reflects an unwillingness to face problems of social control and social discipline, while trusting some technological device to extricate society from its difficulties. The irony is that the illegitmacy rise occurred precisely while contraception was becoming more, rather than less, widespread and respectable.[11]

We are living in an age in which sexual encounters are condoned and glamorized. Young people who have grown up in homes where parents did not take a definite stand on the issue of morality and communicate these truths to their children by example are at an extreme disadvantage when called upon to make a decision regarding their sexuality. (Regretably, social agencies rarely take such a stand either.) Children from broken homes, or homes where parental disharmony pervades, frequently arrive in their teen years with a rather uncertain identity about themselves and those around them. True feelings of security, love, and purpose in life seem rather remote to many of these teenagers. Is it any wonder that, when they achieve some measure of freedom from their parents, they should seek gratification in early sexual encounters, without much thought of the consequences? To expect them to grasp the significance of the consequences is absurd. Peer pressure from other similarly deprived youngsters effectively fans the flames of their passion. The illogical conclusion becomes, "why should I deny myself pleasure when all my friends are enjoying themselves?"

"With the situation as it is now, teens get little if any reinforcement to abstain from sex."

To continue to try to cope with the resultant forces that lead up to teenage pregnancy is not our only task. Painful as it may be, we must look into the mirror and view poor parenting as a primary cause for our present dilemma. After all, what we call peer pressure for early sexual encounters is nothing more than poor parenting multiplied many times. If what John Stuart Mill said in 1863 is true, that morality is not innate but acquired, then what are we doing as parents and physicians to instruct teenagers in this area? We owe it to them to teach them. We fail in our responsibilities as parents and physicians if we do not set moral standards and instead hand out contraceptives.

The only way to effectively prevent pregnancy and build and enhance self-esteem and self-worth is to abstain from sex in the adolescent years. Yes, you say, but as long as there are pubescent teenagers, there will be sex outside of marriage. So should we not teach those that are going to be sexually active anyway the

rudiments on venereal disease and pregnancy prevention? The logic and apparent rightness of this viewpoint is hard to fault. Until you see what it has produced. The findings of Kantner and Zelnik speak for themselves.

The philosophies upon which some of these programs are based state that they cannot make value judgments regarding the rightness or wrongness of sexual activity. I disagree. I submit that unless they do, and until they do, they will be hurting the people they are most trying to help. Teenagers do not need help managing sexual intercourse nearly as much as they need help in forming their own moral codes.

With the situation as it now is, teens get little if any reinforcement to abstain from sex. Let us not blame the times or society, the while sidestepping our personal responsibility in setting guidelines for the sexual behavior of our children. We must take a stand even though it may be unpopular and not in line with the times. I shudder to think what succeeding generations will be like if we do not do this. If we fail to teach our young people a set of values, what are they going to teach their children?

". . . unless and until teenage pregnancy programs reinforce moral values, they will continue to fail in their efforts to effect a significant reduction in teenage pregnancy."

That sexually active teenagers be educated about the reproductive capacity of their bodies is a good thing. But without concomitant education in the spiritual/moral sphere, this education by itself is almost self-defeating. Consider this analogy: Give a person a loaded gun, educate him regarding its use, and loose him in a crowded park without an appreciation for the value of human life. Without the instilling of a moral code you have a potentially dangerous person who can wreck havoc on his own as well as other lives. But, you say, one must teach a person about the gun and how to use it correctly; otherwise that person may, through ignorance and negligence, hurt himself or others. This is true. But can you not see how in the absence of a moral code in which human life is valued, he is still dangerous?

I contend that unless and until teenage pregnancy prevention programs reinforce moral values, they will continue to fail in their efforts to effect a significant reduction in teenage pregnancy.

Edgar Woody Jr., M.D.
Editor

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Cancer Risk in DES-Exposed Offspring

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DES (diethylestilbestrol or stilbestrol), a synthetic estrogen-type hormone, was first synthesized in the late 1930's. In the 1940's and 1950's, many physicians in the United States and other countries prescribed it for pregnant women. Several research studies suggested that with complications of pregnancy, such as threatened abortion, toxemia, or diabetes, this drug improved fetal survival. Although its use in pregnancy has been discontinued, DES remains a useful therapeutic agent for menopausal symptoms, certain cases of prostate and breast cancer, and a few other clinical problems. See Table 1 for a list of DES-type drugs.

In an epidemiologic study of eight cases in 1971, Herbst and associates reported a link between maternal DES therapy during pregnancy and the later occurrence of clear-cell adenocarcinoma of the vagina in the female offspring exposed to the drug in-utero.[1] This initial report was soon confirmed by others. Studies of the clinical, epidemiologic, and pathologic aspects of these cancers in women born in 1940 or later, have been undertaken by centralizing pertinent data in the Registry for Research on Hormonal Transplacental Carcinogenesis† (formerly the Registry of Clear Cell Adenocarcinoma of the Genital Tract in Young Females). An attempt has been made to accession and investigate all cases of clear-cell adenocarcinoma in this age group whether or not a history of maternal medication was obtained by the patient's physician. Cases of other histologic types of genital cancer are also accessioned if the patient has a history of prenatal hormone exposure.

In 1971, there were 21 cases reported to the Registry.[2] By the end of 1976, a total of 333 cases of clear-cell adenocarcinoma (213 vaginal and 120 cervical) had been accessioned.[3, 4] By 1977, a total of 341 cases had been completely analyzed, and an additional 48 cases had been identified but not completely investigated.[5] Among the cases for which a maternal history was available, approximately two-thirds were associated with intrauterine exposure to DES or a chemically related estrogen. The dosage and duration of DES therapy varied widely in the cases studied. As little as 1.5 mg. taken daily during pregnancy has been associated with the subsequent development of cancer in the female offspring, as has the administration of the drug for as short an interval as 7 days during the first trimester. However, because DES was not administered to some of the mothers of these cancer patients, factors other than maternal hormone administration may also play a role in the etiology of these tumors.

Although the exact number of pregnant women treated with DES or chemically similar compounds during pregnancy is unknown, it has been estimated to be as

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TABLE 1
DES-TYPE DRUGS

Benzestrol	Domestrol	Microest
Hexestrol	Mestilbol	Delvinal-DES
Milestrol	Oestromon	Stils
Tace	Stilbinol	Stilpalmitate
Cyren A	Synestrol	Stiphostrol
Estrobene	Mikarol Forti	Neo-Oestranol II
Neo-Oestranol I	Stilbal	Pabestrol D
Oestromenin	Restol	Stilboestrol D.P.
Synthoestrin	Cyren B	Digestil
Stilboestroform	Estan	Estrobene DP
Synestrin	Teserene	Dienoestrol
Di-Estryl	Metystil	Willestrol
Hi-Bestrol	Dienestrol	Diastyl
Mikarol	Meprane	Methallenestril
Stil-Rol	Monomestrol	Stibestrol
Diethylstilbestrol Dipalmitate	Vallestril	Stilrone
Diethylstilbestrol Diphosphate	Comestrol	Nulabort
Diethylstilbestrol Dipropionate	Fonatol	Desplex
Orestol	Oestrogenine	Stilestrate
Stilbestronate	Palestrol	Dibestil
Stilronate	Stilbetin	Menocrine
Estilben	Stilbestrol	Di-Erone
Chlorotrianisene	DES	Amperone
Diethylstylbenediol	Estrosyn	Tylandril

high as 2 million. The actual risk of carcinoma developing in a female exposed to DES is unknown at this time, but in view of the large population exposed and the rare incidence of cancer, the risk appears to be very small. The risk of carcinomas developing in DES-exposed females through the age of 24 years has been estimated to be 0.14-1.4 per 1,000.[5]

A recent analysis of age incidence showed a peak frequency at age 19.5 for those patients with a history of DES exposure.[4, 5] The youngest patient was 7 years old at the time of diagnosis, and the oldest was 29. The peak age of detection of clear-cell adenocarcinoma of the cervix and vagina at 19 years in the Registry cases suggests the possibility that the hormonal events accompanying puberty play some role in carcinogenesis, but such a role is far from clear at the present time.

Non-neoplastic changes are far more common. These are often evident on inspection and include cervical ectropion and transverse cervical and vaginal ridges described by a variety of names, such as, hood, collar, rim, cockscomb cervix, and pseudopolyps. Adenosis, the most common non-neoplastic change, is not always recognized on clinical examination. It appears to be more common with earlier in-utero DES-exposure. No cases have been reported to date in which vaginal adenosis has progressed to cancer under direct observation. Older patients tend to have less adenosis as a result of ''healing'' by squamous metaplasia. In its active stage, squamous metaplasia often appears immature and should not be confused with dysplasia or carcinoma in-situ (CIS). With the use of microspectrophotometric determinations of nuclear DNA content in vaginal and cervical squamous cell abnormalities, it is possible to separate squamous metaplasia (euploid DNA values) and mild dysplasia (polypoid) from more severe dysplasias (aneuploidy).[6] The aneuploid DNA histogram is believed to be indicative of a more ominous and significant precursor lesion.

Three invasive squamous cell carcinomas have been accessioned by the Registry in DES-exposed progeny. In 1974, Stafl and Mattingly[2] expressed the initial concern that the major clinical risk in DES-exposed women was the development of squamous neoplasia of the vagina and cervix, rather than clear-cell carcinoma.[7] They predicted that squamous cell carcinoma would be more common in the DES-exposed subject because of the frequent, large size of the transformation zone.

In 1976, they reported that the prevalence of CIS in DES-exposed girls (1.4%) was nearly five times the prevalence rate of CIS in a control group of 5,808 DES-unexposed women (0.44%).[8] However, variations in the reported frequency of dysplasia are most likely due to differences in the interpretation of the cellular and the histopathologic evidence (overdiagnosis) as well as to the problem of ascertainment. The microspectrophotometric data suggest that overdiagnosis of squamous lesions in DES offspring is a problem.[9]

There have been some recent publications regarding potential problems of infertility and increased pregnancy wastage in DES-exposed offspring.[10, 11] In view of the limited number of cases that have been examined, additional studies must be completed before drawing any conclusions about this problem. Epididymal cysts, hypoplastic testes, cryptorchidism, and semen abnormalities occur more frequently in DES-exposed males, but to date, no evidence of malignancy has been found in the limited number of DES-exposed males examined.[12] In females, prenatal DES exposure did not appear to increase the frequency of kidney or ureteral abnormalities, as judged by the results of intravenous pyelograms.[13]

A frequently asked question regarding the care of the DES-exposed young woman is whether or not oral contraceptives should be prescribed. There is no evidence that oral contraceptives are either helpful or harmful to a patient with vaginal adenosis. However, because of the uncertainty of the effects of these hormones on a disorder caused by another hormone, many physicians have preferred not to recommend oral contraceptives for their DES-exposed patients. Structural changes will sometimes prevent the use of a diaphragm.

A rare condition, microglandular hyperplasia, associated with use of oral contraceptives, has been described recently on a background of vaginal adenosis by Registry pathologists.[14] Although the lesion is not harmful in itself, it can be confused with adenocarcinoma by the pathologist, and it is important that he be informed by the gynecologist whenever a patient is on oral contraceptives to avoid a wrong diagnosis. The lesion may also be encountered during pregnancy and can occur in the absence of oral contraceptive use or pregnancy as well.

It is usually recommended that a young woman exposed to DES in-utero have an examination once she begins to menstruate, or at about the age of 14 years, if menstruation has not occurred by that time. If a pre-pubertal child has any symptoms possibly related to the presence of a vaginal or cervical tumor, an immediate examination, which usually must be performed under anesthesia, is mandatory. Before undertaking the examination, the entire procedure should be thoroughly discussed with the patient (and her mother, if the child is a minor). An adequate examination includes careful palpation and inspection of the entire vagina and cervix and careful cytologic sampling by direct scraping separately of the vagina and portions of the cervix.

Colposcopy is done by most gynecologists, although this is not essential for a satisfactory screening examination. Colposcopy can be helpful in the diagnosis of adenosis, but no specific colposcopic changes compatible with clear-cell adenocarcinoma have been described; indeed, small carcinomas that were easily palpable were not visible in three patients examined carefully by experienced gynecologists, usually because of their location submucosally or behind an obstructing fibrous ridge. In addition, the squamous cell changes, noted so frequently in the DES-exposed offspring, are confusing and make the colposcopic differentiations of benign and neoplastic changes difficult. The tissues of the DES progeny show a marked similarity to the immature transformation zone in young, sexually active adolescents. In the exposed offspring, however, the immature metaplasia persists for a much longer period of time than in their non-exposed counterparts. As a consequence, the physician must be cautious in interpreting the colposcopic findings. The technique should not be abandoned, however, for it does permit one to accurately assess the extent of epithelial change, and it is most useful in directing biopsies in exposed individuals with an abnormal Papanicolaou (Pap) test in which dysplastic cells have been noted.

Iodine staining (with half-strength Lugol's solution) is even less precise than colposcopy in detecting malignancies, but it gives an accurate assessment of the extent of the epithelial changes. Glycogen-poor tissues that will not stain with iodine include adenosis, immature metaplasia, clear-cell adenocarcinoma, dysplasia, and CIS. As a consequence, one cannot rely upon this technique for the detection of malignancies in the DES-exposed patient.

The following findings require tissue sampling:

1. Indurated or unusually firm or cystic areas in the vagina or on the cervix.
2. Discrete areas that appear to be a different color and texture than surrounding tissue, i.e., focal, red, or irregular.
3. Highly abnormal colposcopic findings, i.e., heavy mosaic, punctuation, atypical vessels.

It is not necessary to randomly sample non-staining areas of the vagina or the cervix.

The interval for follow-up examinations has, to date, been arbitrarily determined at 6 months, but after a normal initial examination, annual pelvic examinations, with cervical and vaginal cytology, are probably adequate. Of course, if the patient has an abnormal Pap test, the interval should be adjusted. If any abnormalities are noted during the initial evaluation, more frequent follow-up examinations are suggested (every 3 to 6 months, depending on the severity of the findings).

Finally, the greatest problem the physician will probably encounter about DES exposure is the anxious mother who calls in, distraught over recent television and newspaper articles. In this situation, considerable patience is critical and reassurance is mandatory. One must point out the rarity of clear-cell adenocarcinoma, even in the exposed subject, while emphasizing the need for a proper and careful examination.

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Tax Shelters — 1979

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THE SUBJECT of tax shelter investments is a complex one. Without attempting to be an in-depth treatment of the subject, this article will touch on some of the highlights of current developments in the tax shelter area, emphasizing recent legislative changes.

In recent years, both Congress and the Internal Revenue Service (IRS) have been limiting the availability and attractiveness of tax shelters. The Tax Reform Act of 1976 and the Revenue Act of 1978 have severely limited the availability of multiple write-off shelters. Also, the IRS has recently focused on some areas of abuse in tax shelters, and has issued a number of adverse rulings intended to have a negative effect on the sale of tax shelters. The IRS has increased its audit coverage of tax shelters and is also going to court more frequently to attempt to deny the deductions claimed in many tax shelters. As a result, in many instances taxpayers have been requested to hold open tax returns as far back as 1973 pending the outcome of litigation involving tax shelter issues present in such returns.

Against this backdrop, let us examine the current status of tax shelters.

Mechanics and Purpose

From a tax standpoint, tax shelters have two purposes: to defer taxes and, in some instances, to convert ordinary income into capital gain. The foundation of tax shelter investments has been the use of nonrecourse debt. Nonrecourse debt is debt on which the borrower does not have any personal liability. The lender's only rights are against the property securing the debt. The presence of nonrecourse debt has enabled investors to deduct amounts in excess of their actual investment without bearing the risk of ever being called on to pay any portion of that debt out of their own pocket. It is important to keep in mind that at some point in the future (usually upon sale or foreclosure of the investment, or upon realization of income from the investment), an amount equal at least to the deductions in excess of actual investment will have to be taken back into the income of the investor even if no cash is received. That is why tax shelters are mainly a technique to defer income. In fact, in many situations the original deductions will shelter income which would have been taxed at the 50% rate but will subsequently come back into income at a 60% or 70% rate because the income will not be subject to the 50% maximum on earned income. Of course, there is the possibility of sheltering the income at that time. Also, in some investments, a substantial portion of the income may be taxable at the lower capital gain rates. This would be the best type of tax oriented investment, since the investor would have succeeded in both deferring taxes and also in converting his income into capital gain taxed at a lower rate.

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At-Risk Limitation

The most significant piece of legislation in the tax shelter area involves the so-called "at-risk limitation" which originally became law under the Tax Reform Act of 1976. It has since been made more stringent under the Revenue Act of 1978, effective for tax years beginning in 1979. The at-risk limitation generally applies to all investments of individuals, partnerships, Subchapter S corporations, and certain other closely-held corporations, with the exception that the limitation does not apply to real estate investments other than mineral property. The at-risk limitation limits the losses that can be deducted by an investor to the amount of capital that he has invested plus the amount of debt on which the investor is personally liable. Thus, except in real estate investments, investors may no longer obtain losses in excess of their invested capital (multiple write-offs) as a result of incurring nonrecourse debt. If the investor is to obtain a multiple write-off, he generally must to some extent bear the economic risk represented by the indebtedness incurred in the project. Thus, the old type of blatant tax shelter of (a) invest $10,000, (b) give a $90,000 nonrecourse note, (c) obtain a 10 to 1 write-off and (d) forget about whether or not you will ever get your money back, is pretty much dead.

It should be noted that many multiple write-off tax shelters are under attack by the IRS even for years to which the at-risk limitation does not specifically apply based in part on what might be described as an economic at-risk limitation. The IRS takes the position (and at least two courts have agreed) that in order for a taxpayer to deduct losses based on nonrecourse indebtedness, he must show that the property which is the subject of the shelter (e.g. movies, books, cable T.V., lithographs, mineral leases, real estate) is at least equal in value to the amount of the nonrecourse debt which the property secures. In many instances, where the acquisition cost of the subject property was inflated through the use of nonrecourse debt in order to maximize tax deductions, there will be difficulty in meeting this fair market value requirement.

The Revenue Act of 1978 also included new "at-risk recapture" rules. Under these rules, at the end of any tax year in which a taxpayer's at-risk amount in an investment is reduced below zero, the investor recognizes ordinary taxable income to the extent of the negative at-risk amount. As previously stated, an investor's at-risk amount is equal to the amount of capital he invested plus any debt on which he is personally liable. This at-risk amount may be reduced in three ways: (1) By losses deducted as a result of the investment; (2) by cash received from the investment in excess of taxable income; and (3) by the change of debt status from recourse to nonrecourse.

Here is an example of the possible operation of this provision:

Assume the person invested $10,000 in a project and incurred a $30,000 recourse debt, payable interest only the first 3 years, resulting in his being at risk in the amount of $40,000. Over 3 years, the investor deducted $25,000 in losses, reducing his at-risk amount to $15,000. At the end of the third year, the agreement provides that the debt becomes nonrecourse. This would result in the at-risk amount being reduced at that time by $30,000 to a negative amount of $15,000. The investor would have to include that $15,000 in his income as ordinary income.

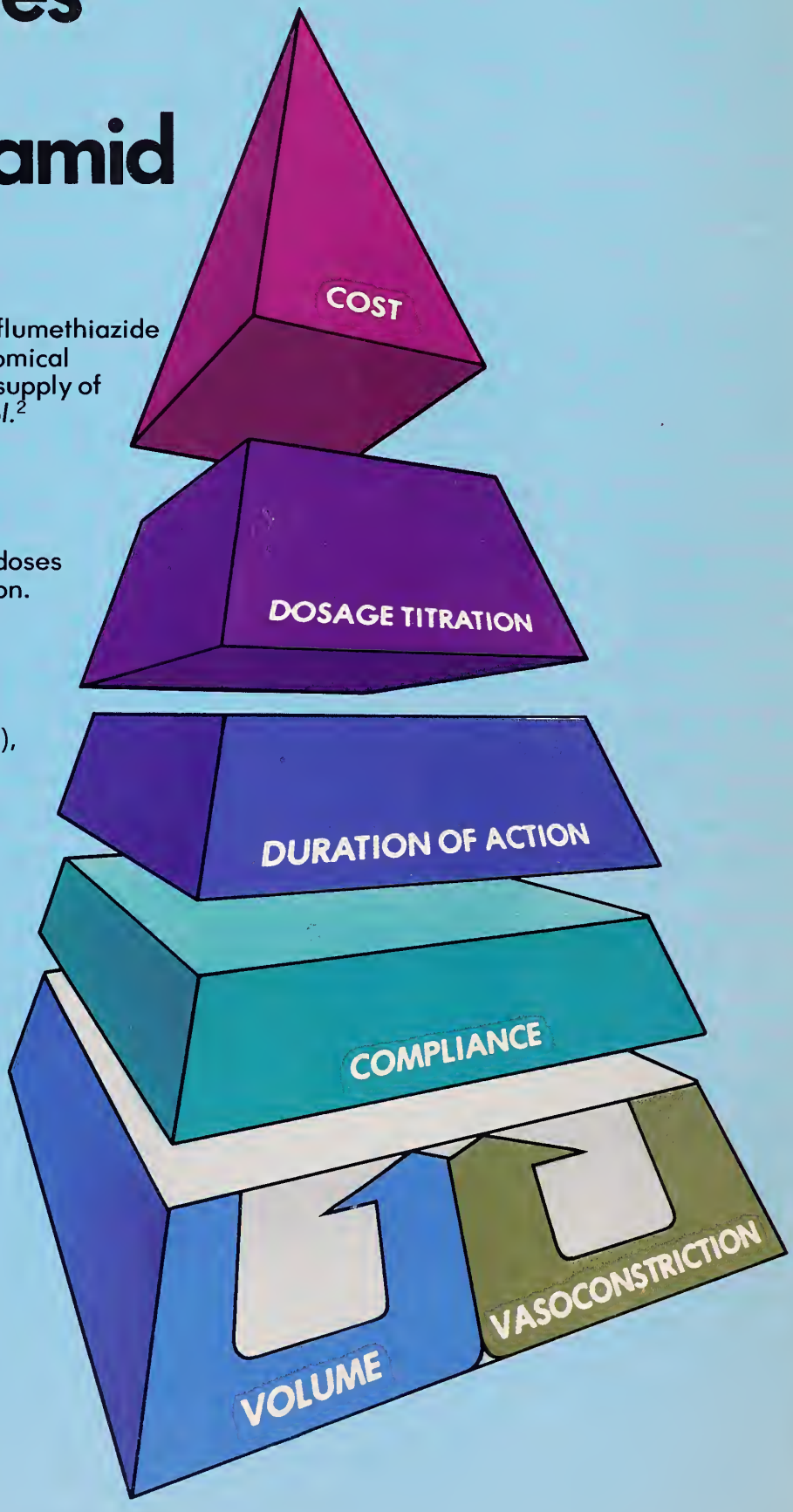
Again, it should be emphasized that the statutory at-risk limitation and at-risk recapture rules do not apply to real estate investments.

Tax Preference Items

Since 1969, the Internal Revenue Code has contained unfavorable provisions with regard to tax preference items. First, there is an add-on minimum tax which presently is equal to 15% of the amount by which a taxpayer's tax preference items exceed the greater of $10,000 or one-half of the regular income taxes paid by the taxpayer for the taxable year. This minimum tax is in addition to the regular income taxes which would be owed by the taxpayer. Tax preference items also reduce on a dollar-for-dollar basis the amount of earned income eligible for the 50% maximum tax. The most common tax preference items which might be present in tax shelter investments would be (a) the amount of accelerated depreciation in excess of the

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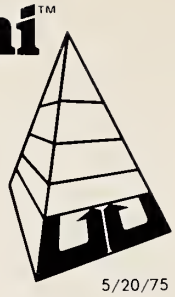
For a summary of prescribing information, please see following page.

Saluron®
(hydroflumethiazide 50 mg.)

Salutensin®
(hydroflumethiazide 50 mg./reserpine 0.125 mg.)

Salutensin-Demi™
(hydroflumethiazide 25 mg./reserpine 0.125 mg.)

structured for the long run in "step two" hypertension



Saluron® (hydroflumethiazide) 5/20/75

For complete information consult Official Package Circular.

CONTRAINDICATIONS: Patients with anuria, oliguria, or hypersensitivity to this or other sulfonamide derived drugs.

WARNINGS: Saluron should be used with caution in severe renal disease. In patients with renal disease, thiazides may precipitate azotemia. Cumulative effects of the drug may develop in patients with impaired renal function.

Thiazides should be used with caution in patients with impaired hepatic function or progressive liver disease, since minor alterations of fluid and electrolyte balance may precipitate hepatic coma. Thiazides may be additive or potentiative of the action of other antihypertensive drugs. Potentiation occurs with ganglionic or peripheral adrenergic blocking drugs.

Sensitivity reactions may occur in patients with a history of allergy or bronchial asthma.

The possibility of exacerbation or activation of systemic lupus erythematosus has been reported.

Usage in pregnancy: Usage of thiazides in women of childbearing age requires that the potential benefits of the drug be weighed against its possible hazards to the fetus. These hazards include fetal or neonatal jaundice, thrombocytopenia, and possibly other adverse reactions which have occurred in the adult.

Nursing mothers: Thiazides cross the placental barrier and appear in cord blood and breast milk.

PRECAUTIONS: Periodic determination of serum electrolytes to detect possible electrolyte imbalance should be performed at appropriate intervals.

All patients receiving thiazide therapy should be observed for clinical signs of fluid or electrolyte imbalance; namely, hyponatremia, hypochloremic alkalosis, and hypokalemia. Serum and urine electrolyte determinations are particularly important when the patient is vomiting excessively or receiving parenteral fluids. Medication such as digitalis may also influence serum electrolytes. Warning signs, irrespective of cause, are: Dryness of mouth, thirst, weakness, lethargy, drowsiness, restlessness, muscle pains or cramps, muscular fatigue, hypotension, oliguria, tachycardia, and gastrointestinal disturbances such as nausea and vomiting.

Hypokalemia may develop with thiazides as with any other potent diuretic, especially with brisk diuresis, when severe cirrhosis is present, or during concomitant use of corticosteroids or ACTH.

Interference with adequate oral electrolyte intake will also contribute to hypokalemia. Digitalis therapy may exaggerate metabolic effects of hypokalemia especially with reference to myocardial activity.

Any chloride deficit is generally mild and usually does not require specific treatment except under extraordinary circumstances (as in liver disease or renal disease). Dilutional hyponatremia may occur in edematous patients in hot weather; appropriate therapy is water restriction, rather than administration of salt except in rare instances when the hyponatremia is life threatening. In actual salt depletion, appropriate replacement is the therapy of choice.

Hyperuricemia may occur or frank gout may be precipitated in certain patients receiving thiazide therapy.

Insulin requirements in diabetic patients may be increased, decreased or unchanged. Latent diabetes mellitus may become manifested during thiazide administration.

Thiazide drugs may increase the responsiveness to tubocurarine.

The antihypertensive effects of the drug may be enhanced in the postsympathectomy patient.

Thiazides may decrease arterial responsiveness to norepinephrine. This diminution is not sufficient to preclude effectiveness of the pressor agent for therapeutic use.

If progressive renal impairment becomes evident, as indicated by a rising nonprotein nitrogen or blood urea nitrogen, a careful reappraisal of therapy is necessary with consideration given to withholding or discontinuing diuretic therapy.

Thiazides may decrease serum PBI levels without signs of thyroid disturbance.

ADVERSE REACTIONS:

A. Gastrointestinal system reactions: Anorexia, gastric irritation, nausea, vomiting, cramping, diarrhea, constipation, jaundice (intrahepatic cholestatic jaundice), pancreatitis.

B. Central nervous system reactions: Dizziness, vertigo, paresthesias, headache, xanthopsia.

C. Hematologic reactions: Leukopenia, agranulocytosis, thrombocytopenia, aplastic anemia.

D. Dermatologic-Hypersensitivity reactions: Purpura, photosensitivity, rash, urticaria, necrotizing angiitis (vasculitis) (cutaneous vasculitis).

E. Cardiovascular reaction: Orthostatic hypotension may occur and may be aggravated by alcohol, barbiturates, or narcotics.

F. Other: Hyperglycemia, glycosuria, hyperuricemia, muscle spasm, weakness, restlessness.

Whenever adverse reactions are moderate or severe, thiazide dosage should be reduced or therapy withdrawn.

USUAL DOSE: The average adult diuretic dose is 25 to 200 mg. per day. The average adult antihypertensive dose is 50 to 100 mg. per day. Therapy should be individualized according to patient response. This therapy should be titrated to gain maximal therapeutic response as well as the minimal dose possible to maintain that therapeutic response.

HOW SUPPLIED: Saluron (hydroflumethiazide 50 mg.): Bottles of 100.

Salutensin® • Salutensin-Demi™ (12) 10/27/78

(hydroflumethiazide, reserpine antihypertensive formulation)

For complete information consult Official Package Circular.

> **WARNING**
> This fixed combination drug is not indicated for initial therapy of hypertension. Hypertension requires therapy titrated to the individual patient. If the fixed combination represents the dosage so determined, its use may be more convenient in patient management. The treatment of hypertension is not static, but must be reevaluated as conditions in each patient warrant.

CONTRAINDICATIONS: Anuria, oliguria, active peptic ulceration, ulcerative colitis, severe depression or hypersensitivity to its components contraindicates the use of Salutensin.

WARNINGS: Small-bowel lesions (obstruction, hemorrhage, perforation and death) have occurred during therapy with enteric-coated formulations containing potassium, with or without thiazides. Such potassium formulations should be used with Salutensin only when indicated and should be discontinued immediately if abdominal pain, distention, nausea, vomiting or gastrointestinal bleeding occurs. Use cautiously, and only when deemed essential, in fertile, pregnant or lactating patients.

Use in pregnancy: Thiazides cross the placenta and can cause fetal or neonatal hyperbilirubinemia, thrombocytopenia, altered carbohydrate metabolism and possibly electrolyte disturbances. Fatal reactions may occur with reserpine during electroshock therapy; discontinue Salutensin 2 weeks before such therapy. Increased respiratory secretions, nasal congestion, cyanosis and anorexia may occur in infants born to reserpine-treated mothers.

PRECAUTIONS: Azotemia, hypochloremia, hyponatremia, hypochloremic alkalosis and hypokalemia (especially with hepatic cirrhosis and corticosteroid therapy) may occur, particularly with pre-existing vomiting and diarrhea. Potassium loss may cause digitalis intoxication. *Potassium loss responds to potassium-rich foods, potassium chloride or, if necessary, discontinuation of therapy.* Serum ammonia elevation may precipitate coma in precomatose hepatic cirrhotics. Discontinue therapy 2 weeks before surgery or if myocardial irritability, progressive azotemia or severe depression occur. Exercise caution in patients with chronic uremia, angina pectoris, coronary thrombosis or extensive cerebral vascular disease or bronchial asthma and in those with a history of peptic ulceration or bronchial asthma; in postsympathectomy patients; in patients on quinidine; and in patients with gallstones, in whom biliary colic may occur. Patients who have diabetes mellitus or who are suspected of being prediabetic should be kept under close observation if treated with this agent.

ADVERSE REACTIONS: Hydroflumethiazide: Skin-rashes (including exfoliative dermatitis), skin photosensitivity, urticaria, necrotizing angiitis, xanthopsia, granulocytopenia, aplastic anemia, orthostatic hypotension (potentiated with alcohol, barbiturates or narcotics), allergic glomerulonephritis, acute pancreatitis, liver involvement (intrahepatic cholestatic jaundice), purpura plus or minus thrombocytopenia, hyperuricemia, hyperglycemia, glycosuria, malaise, weakness, dizziness, fatigue, paresthesias, muscle cramps, skin rash, epigastric distress, vomiting, diarrhea and constipation. **Reserpine:** Depression, peptic ulceration, diarrhea, Parkinsonism, nasal stuffiness, dryness of the mouth, weight gain, impotence or decreased libido, conjunctival injection, dull sensorium, deafness, glaucoma, uveitis, optic atrophy, and, with overdosage, agitation, insomnia and nightmares.

USUAL DOSE: 1 tablet b.i.d.

HOW SUPPLIED: Salutensin (hydroflumethiazide 50 mg., reserpine 0.125 mg.): Bottles of 100 and 1000.

Salutensin-Demi (hydroflumethiazide 25 mg., reserpine 0.125 mg.): Bottles of 100.

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amount which would have been allowable as straight-line depreciation on real property and on leased personal property, (b) a portion of the depletion allowance on mineral properties, and (c) a portion of the intangible drilling costs with respect to oil and gas properties. Capital gains and excess itemized deductions are no longer tax preference items for purposes of the add-on minimum tax and the 50% maximum tax. However, the Revenue Act of 1978 added an alternative minimum tax. In general, the alternative minimum tax is a graduated percentage of the sum of the taxpayer's taxable income plus any excess itemized deductions (itemized deductions, with certain exceptions, the sum of which exceeds 60% of adjusted gross income) plus the 60% of capital gain that is excluded from income. If the alternative minimum tax exceeds a taxpayer's normal income tax plus any add-on minimum tax, the taxpayer pays the alternative tax. The main effect of this provision is, in most situations, to make it impossible to shelter large capital gains.

Estate Aspects

Generally, a gift of property subject to indebtedness in excess of the donor's basis (generally equal to cost minus depreciation) in the property will result in taxable income to the extent of such excess. However, in the past, the passage of property subject to indebtedness in excess of basis as a result of death has not been considered to be a taxable transaction. As most people know, the Tax Reform Act of 1976 enacted new carryover basis rules. Under these rules, the beneficiaries of an estate take the decedent's tax basis in property left to them rather than a basis equal to the fair market value of the property when the decedent died, as had been the law. As a result of this provision, tax lawyers have focused attention on whether, similar to the gift situation, there is a taxable disposition of property as a result of death where the property is subject to an indebtedness in excess of the decedent's basis. It has been speculated that there could be a disposition upon death, resulting in the gain being taxable in the final tax return of the decedent, or there could be a disposition when the executor transfers the property to the beneficiary under the decedent's will, or there may be no taxable disposition at all. This problem has not been resolved. The carryover basis rules have been suspended until 1980. However, even if the carryover basis rules were to be repealed, there is still no assurance that the IRS might not take the position that gain must be included in the final return of the decedent to the extent he owns property secured by debt in excess of the decedent's basis.

This is a highly technical and complex question, a detailed discussion of which is beyond the scope of this article. However, people owning property subject to indebtedness in excess of basis should be cognizant of this problem in planning their estates.

Summary

In the past, many people have invested in tax shelters which promised large deductions but had little economic viability. For the most part, these shelters will no longer be available due to the at-risk limitations. To the extent they remain available, the economic risks which will have to be incurred by the investor in order to be eligible for the deductions will generally make such investments unattractive.

In analyzing investments containing tax benefits, investors should generally look at them not as tax shelters but as tax-oriented investments with a heavy emphasis on the investment aspect. Although the IRS is attempting to reduce the amount of front-end deductions available in real estate investments, improved real estate appears today to be the most attractive tax-oriented investment due to attractive tax benefits, including exemption from the at-risk limitation and the inherent possibilities of appreciation in value of such an investment. Oil and gas may also offer reasonably good economic potential along with some tax benefits, such as the deduction of depletion and intangible drilling costs. Of course, great care must be taken in analyzing both the economic potential and the tax aspects of a potential investment; and an investor should consider obtaining professional advice regarding both those aspects.

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NEW MEMBERS

Anderson, William B., Muscogee—I&R—FP
P.O. Box 951, Columbus 31902

Benitez, Robert E., Muscogee—ACT—PTH
P.O. Box 4199, Columbus 31904

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Bush, Robert H., Muscogee—I&R—FP
P.O. Box 951, Columbus 31902

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Filstein, Allen B., MAA—A—D
1395 Normandy Dr., #3, Atlanta 30306

Gerson, Edwin Steven, Clayton-Fayette—ACT—R
Box 608, Riverdale 30274

Giles, Jackson T., Coweta—N2—OPH
Box 609, Newnan 30264

Goldman, Stephen R., MAA—ACT—OBG
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Memorial Medical Center, Savannah 31405

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Kloster, Gilbert J., MAA—ACT—PS
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1670 Clairmont Rd., Decatur 30033

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P.O. Box 348, Springfield 31329

McNaughton, Philip Z., GA Med. Soc.—N2—D
6409 Abercorn, Savannah 31405

Mitchell, Richard M., MAA—N2—OBG
35 Collier Rd., Ste. 320, Atlanta 30309

Morgan, Philip E., MAA—ACT—OM
2000 Northeast Expressway, Norcross 30071

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Ogburn, Charles L. Jr., Bibb—N2—IM
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Patel, Manharbhai N., Spalding—N2—GS
610 S. Eighth St., Griffin 30223

Price, Lawrence W., Muscogee—I&R—FP
P.O. Box 951, Columbus 31902

Smaha, Jerry Joseph, Muscogee—N2—R
Radiology Dept., Medical College of Georgia, Columbus 30902

Smith, Norman Joe, Bibb—N1—ORS
90 Fifth St., Macon 31211

Stanley, Thomas M., GA Med. Soc.—ACT—N
5105 Paulsen St., Ste. 111, Savannah 31405

Struth, Alan G., Peach Belt—N2—IM
725 North Macon, Ft. Valley 31030

Turner, H. Leonard, DeKalb—ACT—IM
1275 MacConnell Dr., Decatur 30033

Varner, J. William, GA Med. Soc.—N2—P
515 E 63rd St., Savannah 31405

Vernon, Minor C., Bibb—N2—PD
2009 Vineville Ave., Macon 31204

Youngberg, John A., MAA—N2—AN
Emory University Clinic, 1365 Clifton Rd., NE, Atlanta 30322

Youngleson, Sharon J., MAA—ACT—P
80 Butler St., SE, Atlanta 30303

Youngworth, Lynda Ann, MAA—A—GS
80 Butler St., SE, Atlanta 30303

PERSONALS

First District

Joseph V. Morrison, M.D., of Savannah, was elected recently as Chief of Staff at Memorial Medical Center. He succeeded **Cliff Cannon, M.D.,** also of Savannah. Other MAG members to hold staff positions are: **Jose Angel, M.D.,** anesthesiology; **Benjamin McReynolds, M.D.,** emergency; **Walker Beeson, M.D.,** internal medicine; **Carl Rosengart, M.D.,** medical education; **Speir Ramsey, M.D.,** obstetrics and gynecology; **Harvey Lebos, M.D.,** oncology; **Clarence W. Rawson Jr., M.D.,** orthopedics; **Jane B. Jennings, M.D.,** pathology; **J. Patrick Evans, M.D.,** pediatrics; **Irwin H. Safer, M.D.,** psychiatry; **William A. Miller, M.D.,** radiology; **Robert Wynn, M.D.,** surgery; and **Irving Victor, M.D.,** urology.

Ivy Shuman Jr, M.D., Sylvania, was recently named a diplomate of the American Board of Family Practice.

Second District

James H. Crowdis, M.D., was honored February 16 at the Blakely Rotary Club when Gus Walters, of the Georgia Heart Association, presented him with a plaque signifying 27 years of service.

Archibald McNeill Jr., M.D., Camilla, has been named a diplomate of the American Board of Family Practice.

Cairo physician, **C. K. Singleton, M.D.,** retired February 28 from his family practice. He was honored with plaques from the Chairman of the County Commission and the Chairman of the Hospital Authority in Cairo. Dr. Singleton is now in charge of the emergency room at Archbold Hospital on a part-time basis.

Brenda H. Thomas, M.D., a Waycross pediatrician, spoke at the February 22 meeting of the Childbirth and Parent Education Association.

Alberto A. Zavaleta, M.D., a thoracic vascular surgeon in Thomasville, spoke to the Thomasville Noon Lions Club at their February 19 meeting. His topic was organ transplants.

Third District

Wallace Lucas, M.D., of Cochran, and **Daniel Nathan, M.D.,** of Fort Valley, were recently named diplomates of the American Board of Family Practice.

Fourth District

Larry Brannon, M.D., of Tucker, has recently joined the staff of the Community Services Counseling Center on Tanner Street in Carrollton.

In March, **John F. O'Brien, M.D.,** Decatur, joined the Department of Dermatology at Emory University School of Medicine.

Arthur L. Tracht, M.D., of Decatur, was recently inducted as a Fellow of the American Academy of Orthopaedic Surgeons at the Academy's 46th annual meeting in San Francisco.

Fifth District

Three MAG members have been named Medical Directors of the critical care units at Saint Joseph's Hospital in Atlanta. The physicians named were **Michael Chorches, M.D.,** progressive coronary care, **Arnoldo Fiedotin, M.D.,** coronary care, and **Ken Thomas, M.D.,** cardiac surgical.

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Brown Dennis, M.D., an endocrinologist at Piedmont Hospital in Atlanta, participated in a meeting in February sponsored by United Parents, a group formed to educate the public about drug use and abuse.

Ray Johnson, M.D., was elected as president of the professional staff of Psychiatric Institute of Atlanta. Also elected were **Thomas Butcher, Ph.D.,** vice president, and **Clifford Beal, M.D.,** secretary.

Robert E. Wells, M.D., an Atlanta orthopedist, was elected second vice president of the American Academy of Orthopaedic Surgeons at the organization's 46th annual meeting, February 22-27, 1978, in San Francisco.



Robert E. Wells, M.D.

James A. Merrill, M.D., Atlanta, was recently recertified as a diplomate of the American Board of Obstetrics and Gynecology.

Arthur P. Richardson, M.D., of the Emory University School of Medicine in Atlanta, was a special guest of honor at the Emory Medical Alumni Association Annual Dinner Dance held March 13. Dr. Richardson plans to retire August 31, 1979, after 23 years as Dean of Emory Medical School. A special presentation was made during the program in recognition of Dr. Richardson's service to the university and medical school.

In March, **Nanette K. Wenger, M.D.,** of Atlanta, received the American Heart Association's 1979 Award of Merit for outstanding service to the Heart Association at the national level.

John Page Wilson, M.D., Atlanta Northside surgeon, acted as general chairman for the 1979 Atlanta Graduate Medical Assembly held at the Omni International Hotel on March 11-14.

Sixth District

Cyler Garner, M.D., Gordon, has been named a diplomate of the American Board of Family Practice.

J. Morgan Kellum, M.D., Thomaston, participated in the Southern Medical Association, Carribean Seminar in March. Dr. Kellum spoke on "Advantages of Spinal Anesthesia for Certain Types of Patients."

E. R. Leverett, M.D., La Grange, was recently named a diplomate of the American Board of Family Practice.

Macon orthopedic surgeon, **A. H. S. Weaver, M.D.,** was elected recently Chief of Medical Staff at the Medical Center of Central Georgia for 1979.

Seventh District

The new 1979 medical staff officers for Douglas General Hospital have been named. They are: **J. Gordon Barrow, M.D.,** President; **Joseph G. Bussey Jr., M.D.,** President-Elect; **Hector J. Curiel, M.D.,** Immediate Past President; and **Howard J. Colier, M.D.,** Secretary-Treasurer.

William D. Cabot, M.D., of Smyrna, was inducted recently as a Fellow of the American Academy of Orthopedic Surgeons at the Academy's 46th Annual Meeting in San Francisco in February.

Ted Cash, M.D., of Chickamauga, was recently elected chief of the medical staff of Hutcheson Memorial Tri-County Hospital for 1979. He succeeds **Richard K. Cureton, M.D.** Other MAG members chosen to staff positions include: **F. Jones Smiley, M.D.,** vice chief of staff; **Thomas E. Hayes, M.D.,** elected chief of surgical service; **Willem K. Rivenburg, M.D.,** chief of medical service; **Thomas H. Curtis, M.D.,** chief of ob-gyn service. Elected as at-large members were **Ralph R. Greene, M.D.,** and **Bruce A. Elrod, M.D.**

S. B. Kitchens, M.D., of Lafayette, was honored with a special article in the February 4 issue of the *Walker County Messenger*. The article celebrated Dr. Kitchens 50th anniversary as a practicing physician in Lafayette.

Clark Robinson, M.D., of Douglasville, **William Tryon, M.D.,** of Marietta, and **Bill Lee Wallace, M.D.,** also of Marietta, have been named diplomates of the American Board of Family Practice.

Eighth District

Charles Bagley, M.D., of Alma, was recently named a diplomate of the American Board of Family Practice.

Mack V. Greer, M.D., of Homerville, was elected recently Chief of Staff-elect for 1980 at South Georgia Medical Center in Valdosta.

George Heath, M.D., Waycross, was recently named a diplomate of the American Board of Family Practice.

Royce Williams, M.D., Homerville, was named recently a diplomate of the American Board of Family Practice.

Ninth District

James Harvey, M.D., Dahlonega, was recently named a diplomate of the American Board of Family Practice.

Barton McCrum, M.D., of Gainesville, presented a paper on "Placenta Accreta" at the Emory University Obstetrics and Gynecology postgraduate course held at Snowmass, Colorado in March.

Cecil Miller, M.D., Buford, was named recently a diplomate of the American Board of Family Practice.

Tenth District

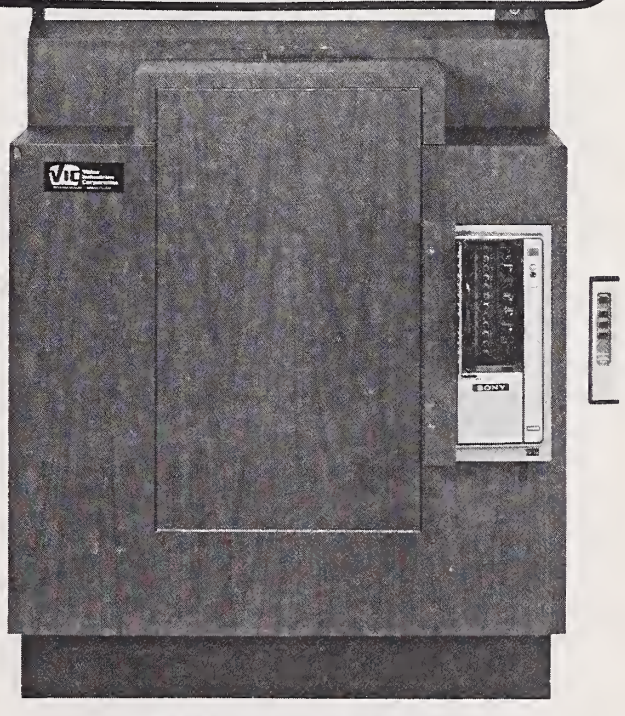
This year the students of Athens Academy's Middle School life science program heard several local doctors and specialists on subjects regarding the human body. Physicians who have participated in the program are: **Don Branyon, M.D.,** gynecologist; **Harvey Cabaniss, M.D.,** dermatologist; **Jim Clay, M.D.,** pathologist; **Golden Hinton, M.D.,** ophthalmologist; **Bob Payne, M.D.,** urologist; **B. P. Tillman, M.D.,** orthopedic surgeon; and **Joseph Williams, M.D.,** neurosurgeon.

M. Lynn Ferrell, M.D., Sparta, and **L. K. Lewis, M.D.,** Madison, were recently named diplomates of the American Board of Family Practice.

SOCIETIES

The Biofeedback Society of Georgia, an affiliate of the Biofeedback Society of America, met at Emory University on Thursday, February 8, 1979. Joseph Bussey Jr., M.D., of Austell was elected as Chairman of the Board of Directors. The Biofeedback Society of Georgia meets at 7:30 p.m. on the first Thursday night of each month at the Emory Center for Rehabilitation Medicine. Members of

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the medical profession who are interested in biofeedback are invited to attend.

DEATHS

John W. Herndon Jr.

John W. Herndon Jr., M.D., 46, died on Sunday, March 11, 1979, at the Phoebe-Putney Hospital in Albany, following an extended illness.

Born September 24, 1932, in Ware County, Dr. Herndon was a resident of Touchton Woods, Douglas, and a member of the First Baptist Church. He was a member of the Coffee County Medical Society, the Medical Association of Georgia, the American Medical Association, and a Veteran of the Korean war.

Dr. Herndon is survived by his wife, Mrs. Elaine Meeks Herndon, a son and daughter, his parents, two brothers, and one sister.

John Joseph Doolan Jr.

John Joseph Doolan Jr., M.D., 53, died March 12, 1979, at Memorial Medical Center in Savannah.

A native of Savannah, Dr. Doolan was a local obstetrician for 21 years and president of the Obstetrics and Gynecology Associates of Savannah. He graduated from Marist School, Benedictine Military School, and Spring Hill College in Spring Hill, Alabama, before entering St. Louis University School of Medicine in St. Louis, Missouri. He graduated from medical school in 1953 and was commissioned a first lieutenant in the U.S. Army Medical Corps. He served his internship at Walter Reed Hospital in Washington and his residency at St. Louis City Hospital and the Medical College of Georgia in Augusta.

He was a diplomate and a fellow of the American Board of Obstetrics and Gynecology, a member of the American Medical Association, the Medical Association of Georgia, the Georgia State Obstetrics and Gynecology Society, the Georgia Medical Society, and the South Atlantic Association of Obstetrics and Gynecology.

He was on the staffs of St. Joseph's and Candler Telfair hospitals and Memorial Medical Center. Dr. Doolan was associated with William Osborne, M.D., Carson Burgstiner, M.D., and Joseph Edwards Jr., M.D.

Surviving him are his wife, Mrs. Elizabeth Landwher Doolan, three daughters, two sons, his mother, and two brothers.

Remembrances may be sent to the Carmelite Monastery or St. Joseph's Hospital.

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(A Memorial to Dr. Fred P. Manget)

J. BENHAM STEWART, M.D., *Macon**



Fred P. Manget, M.D.

In our materialistic society, it is indeed rare to find a person who is willing to dedicate his entire life to helping others with little thought regarding his own welfare or financial security. Dr. Fred Prosper Manget was such a man.

Dr. Manget was born on January 21, 1880, to the late Elizabeth DePass and Victor Eugene Manget of Marietta, Georgia. He spent his childhood there, under the strong religious (Methodist) influence of his parents. When he was 12 years old, he determined that he would be a medical missionary.

In 1906, Dr. Manget graduated from the Atlanta College of Physicians and Surgeons, which later became Emory University School of Medicine. After 2 years of internship at Grady Memorial Hospital in Atlanta and post-graduate work in New York and at Johns Hopkins University, he applied for work in the mission fields in China. In 1909, 17 years after purposing to do so, he arrived in China as a medical missionary. He was stationed in Huchow, in Chekiang Province. An operating room was fashioned from his study and a simple wooden table served as an operating table. His wife, the former Louise Anderson of Marietta, administered the anesthetic for him during operations. From these rather crude beginnings, Dr. Manget went on to build a 60-bed hospital.

During World War I, this dedicated man volunteered, under the auspices of the American Red Cross, to go to Siberia to help with a typhus epidemic among prisoners. There were an estimated 1 million prisoners there, some of whom were Americans. He later received the Croix de Guerre for this work.

On his return to China, Dr. Manget built a 200-bed hospital with the financial help of the Northern Baptist Church and the Rockefeller Foundation. He was commissioned a Colonel by Generalissimo Chaing Kai-shek. He continued to treat his Chinese patients even after the Japanese occupied his hospital.

Subsequently, the United States Public Health Service asked him to go into the jungles of Burma and West China to treat malaria patients, in an area where the Americans and English were helping the Chinese build a railroad to get supplies to China. When the Japanese cut off this work, he joined his friend, General Clair Chenault, of the famous Flying Tigers. During this time, he inspired the title of the best selling book, by General Robert L. Scott of Macon, "God Is My Co-pilot."

After leaving China in 1949, Dr. Manget went to Seoul, Korea, and worked at the Severance Hospital and Medical School, and at the 8th Army Hospital in Kobe, Japan. After a year of such work, he returned to the United States.

Most people would have been ready for retirement after 40 years of arduous and dedicated work on the mission field, but not Dr. Manget. At the age of 70, he applied to the City of Atlanta for a permit to conduct a free medical clinic for the poor in the slum area of that city. The permit was granted in 1953, and a clinic was opened on Capitol Avenue. For 8 years, "Dr. Fred," as he was affectionately called, labored among these people. He gave his services and even provided free medicine for those who could not get it otherwise. This medicine was provided by The Manget Foundation of Newnan, Georgia, which had been established by his brother, Dan, in 1949. An average of 80-100 patients were seen daily at the clinic. In 1961, the city acquired the entire slum area, including the clinic, under the Urban Renewal Program. The Atlanta Stadium now occupies this area.

* Dr. Stewart is a surgeon, specializing in oncology. His address is 700 Spring St., Macon, GA 31201.

In 1959, Dr. Manget, who had lost his first wife in 1957, married Mrs. W. D. (Jennie Loyall) Anderson of Macon. He subsequently saw the need for medical help to the elderly ill and shut-in patients of Macon. He contacted the Welfare Department and spent Friday afternoon and Saturday visiting the ill and shut-in patients, who were too poor or ill to even reach a free clinic. All day Sunday was then spent in putting together the medicine these people needed and delivering it to them in their homes. On Monday, he went back to Newnan to spend the week at his office treating the needy there.

Sometime after the Clinic in Atlanta was closed, Dr. Manget and "Miss Jennie," as she was affectionately known by her friends, moved to Macon. In spite of the fact that by now Dr. Manget was in his 80's, he started a clinic for needy senior citizens and worked with a dedicated group of volunteers.

In 1974, he received the Annual Award of the Georgia Gerontology Society for his contribution to the aging. In 1976, Dr. Manget received the Civic Endeavor Award from the Medical Association of Georgia, and in 1978, just before his final retirement, he received an award from Bibb County Senior Citizens, Inc., for his service to the poor, the old, and the sick.

Near the end of his life, I visited Dr. Manget in his home. His only concern was that he needed help in seeing all of the needy people. There was no thought of himself. When asked a direct question as to his health and well-being, he replied, "I am doing as well as any man nearly 100 can do, but we need young doctors to take over the work of the Clinic."

His second wife died in 1976, and 2 years later, because of his increasing frailty, he went into a nursing home. On Sunday, January 21, 1979, at the age of 99, Dr. Fred Prosper Manget died. He was, truly, a servant of humanity.

Physician's Recognition Award Recipients

LISTED BELOW *are those physicians in Georgia who have earned the AMA's Physician's Recognition Award from January 11 through February 23, 1979.*

The award was established in 1969 "to recognize, encourage and support physicians who participate regularly in continuing medical education and to emphasize the importance of developing more meaningful continuing medical education opportunities for physicians." A minimum of 150 credit hours of CME must be earned over a three-year period to qualify for the award. The hours may include such activities as conferences, residencies, teaching, writing, private reading, listening to cassettes, home study courses, consultation, and peer review; at least 60 of the hours, however, must be from formal CME programs sponsored or co-sponsored by organizations accredited for these activities.

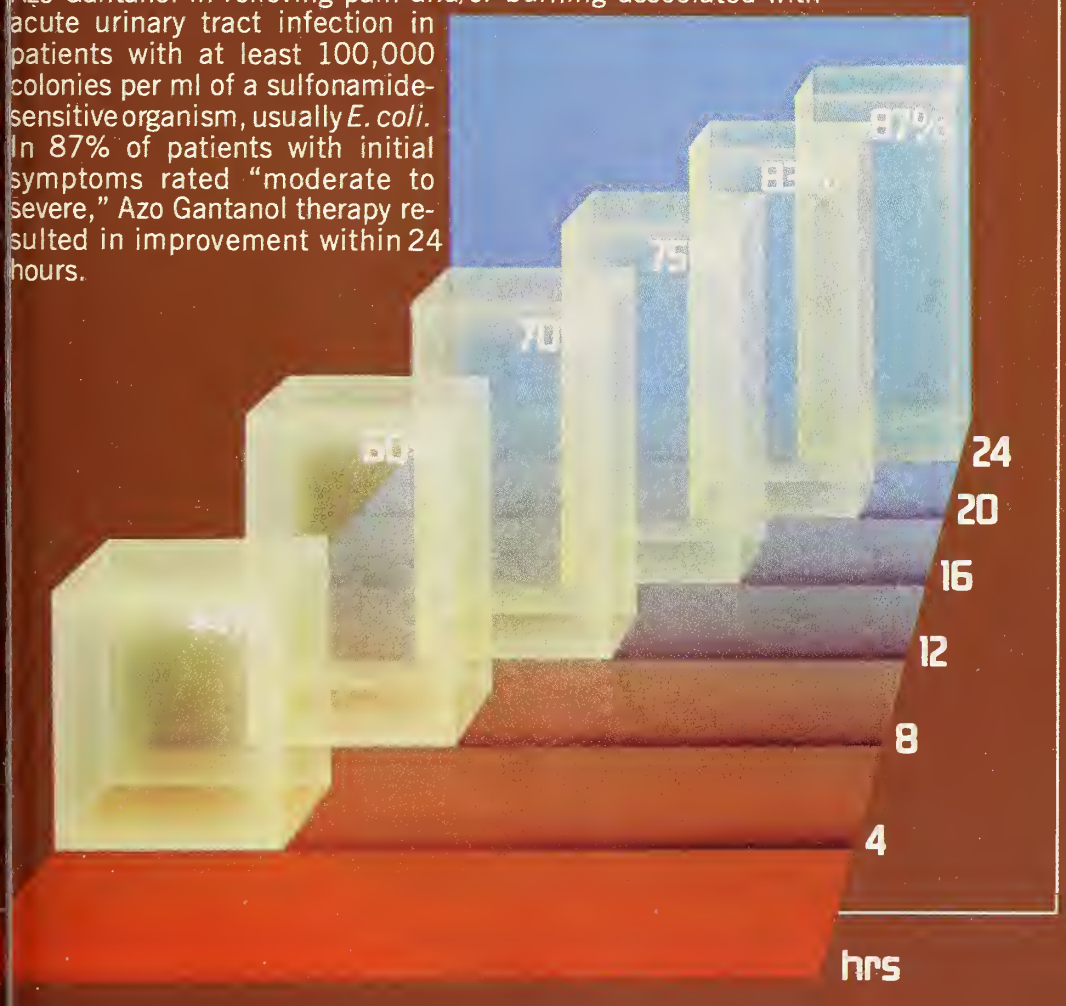
We congratulate the following physicians who have distinguished themselves and their profession by their commitment to continuing education:

Young Whan Ahn, Stone Mountain
Hortensia W. Alvarez, Milledgeville
Julian Alexander Ayres, Atlanta
Luther Edward Brown, Macon
Barbara S. Bruner, Atlanta
John Henry Burson, Atlanta
Miriam Walker Chambless, Hamilton
George Donald Clarke, Savannah
Warren Upton Clary, Savannah
Earl Leo Creech, Valdosta
Benjamin Glover Cruz, Dublin
Ronald Daitch, Augusta
Woodrow W. Defore, Atlanta
Daniel John Dragalin, Atlanta
Stanley Boyd Eaton, Atlanta
J. Candler Guy, Atlanta
Stanley Wm. Hall, La Grange
Otto Bernice Johnson, Dublin
Peter Stuart Johnson, Atlanta
Lewis Edward Jones, Atlanta
Gilbert South Klemann, Albany
William Wallace Leach, Albany
Sue Kim Lee, Atlanta
Louis K. Levy, Atlanta
Joseph A. Manno, Atlanta
Martha L. Smith McCranie, Augusta
Barton Allan McCrum, Gainesville
Peter Leo Meehan, Atlanta
Frederick James Meine, Columbus
Arthur J. Merrill, Atlanta
Henry M. Middleton, Augusta
Homero F. Nino, Decatur
Dillard L. Nix, Athens
Charles Lawton Ogburn, Macon
John Burrell Otis, Atlanta
Peter Michael Payne, Atlanta
Ralph B. Perkerson, Vidalia
Margaret Polk Peters, Atlanta
Thomas Wilson Phillips, Atlanta
Robert Alan Riesenberg, Atlanta
Michael Joseph Rosenberg, Atlanta
M. Aslam Sandvi, Dalton
Gabriel Serrano, Savannah
Ramesh M. Shah, Dublin
Edwin Collier Shepherd, Savannah
Ivy Lee Shuman, Sylvania
Harris Stanley Silverman, Columbus
Jerome P. Sims, Fort Oglethorpe
Manjit Singh, Augusta
Ada Kathleen Skinner, Austell
William Arthur Smith, Atlanta
Miltiadis A. Stefadouros, Augusta
Sidney Fredrick Stein, Atlanta
Carol Richmond Teutsch, Atlanta
Gregory McQueen Thomas, Fort Benning
Joyce Thomas, Decatur
Niranjini C. Tippireddy, Augusta
Robert J. Van De Wetering, Atlanta
Johnathan Paul Vansant, Columbus
Thomas Andrew Wade Jr., Columbus
William George Whitaker, Atlanta
Leslie LaMar Wilkes, Savannah
William A. Wilkes, Augusta
David Adams Williams, Atlanta
Louis Ainsley Wilson, Marietta
John Gordon Zirkle, Savannah

Important data on the pain of acute cystitis:

In 87% of patients studied [303 of 349], Azo Gantanol® reduced pain and/or burning within 24 hours*

A controlled, multicenter study assessed the efficacy of Azo Gantanol in relieving pain and/or burning associated with acute urinary tract infection in patients with at least 100,000 colonies per ml of a sulfonamide-sensitive organism, usually *E. coli*. In 87% of patients with initial symptoms rated "moderate to severe," Azo Gantanol therapy resulted in improvement within 24 hours.



Before prescribing, please consult complete product information, a summary of which follows:

Indications: In adults, urinary tract infections complicated by pain (primarily pyelonephritis, pyelitis and cystitis) due to susceptible organisms (usually *E. coli, Klebsiella-Aerobacter, Staphylococcus aureus, Proteus mirabilis,* and, less frequently, *Proteus vulgaris*) in the absence of obstructive uropathy or foreign bodies. **Note: Carefully coordinate *in vitro* sulfonamide sensitivity tests with bacteriologic and clinical response; add aminobenzoic acid to follow-up culture media. The increasing frequency of resistant organisms limits the usefulness of antibacterials including sulfonamides.** Measure sulfonamide blood levels as variations may occur; 20 mg/100 ml should be maximum total level.

Contraindications: Children below age 12; sulfonamide hypersensitivity; pregnancy at term and during nursing period; because Azo Gantanol contains phenazopyridine hydrochloride it is contraindicated in glomerulonephritis, severe hepatitis, uremia, and pyelonephritis of pregnancy with G.I. disturbances.

Warnings: Safety during pregnancy not established. Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been reported and early clinical signs (sore throat, fever, pallor, purpura or jaundice) may indicate serious blood disorders. Frequent CBC and urinalysis with microscopic examination are recommended during sulfonamide therapy.

Precautions: Use cautiously in patients with impaired renal or hepatic function, severe allergy, bronchial asthma; in glucose-6-phosphate dehydrogenase-deficient individuals in whom dose-related hemolysis may occur. Maintain adequate fluid intake to prevent crystalluria and stone formation.

Adverse Reactions: *Blood dyscrasias* (agranulocytosis, aplastic anemia, thrombocytopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia); *allergic reactions* (erythema multiforme, skin eruptions, Stevens-Johnson syndrome, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis); *G.I. reactions* (nausea, emesis, abdominal pains, hepatitis, diarrhea, anorexia, pancreatitis and stomatitis); *CNS reactions* (headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo and insomnia); *miscellaneous reactions* (drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L. E. phenomenon). Due to certain chemical similarities with some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia. Cross-sensitivity with these agents may exist.

Dosage: Azo Gantanol is intended for the acute, painful phase of urinary tract infections. *Usual adult dosage:* 2 Gm (4 tabs) initially, then 1 Gm (2 tabs) B.I.D. for up to 3 days. If pain persists, causes other than infection should be sought. After relief of pain has been obtained, continued treatment with Gantanol (sulfamethoxazole) may be considered.

NOTE: Patients should be told that the orange-red dye (phenazopyridine HCl) will color the urine.

Supplied: Tablets, red, film-coated, each containing 0.5 Gm sulfamethoxazole and 100 mg phenazopyridine HCl—bottles of 100 and 500.

ROCHE

Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

Fast pain relief plus effective antibacterial action

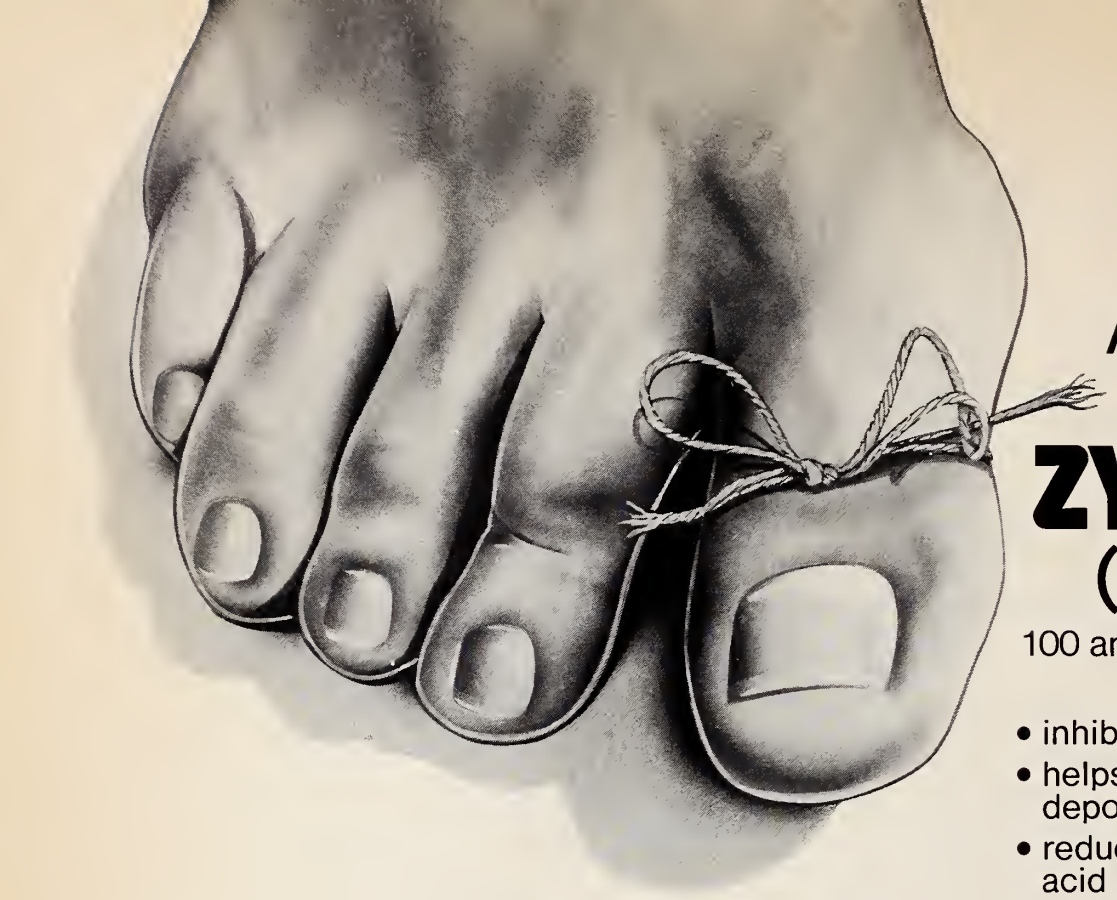
Azo Gantanol®

Each tablet contains 0.5 Gm sulfamethoxazole and 100 mg phenazopyridine HCl.

for the pain

for the pathogens

Data on file, Hoffmann-La Roche Inc., Nutley, New Jersey 07110.



A reminder

ZYLOPRIM®
(allopurinol)

100 and 300 mg scored Tablets

- inhibits uric acid formation
- helps prevent urate crystal depositions in synovia
- reduces risk of uric acid lithiasis

INDICATIONS AND USE: This is not an innocuous drug and strict attention should be given to the indications for its use. Pending further investigation, its use in other hyperuricemic states is not indicated at this time.

Zyloprim® (allopurinol) is intended for:

1. treatment of gout, either primary, or secondary to the hyperuricemia associated with blood dyscrasias and their therapy;
2. treatment of primary or secondary uric acid nephropathy, with or without accompanying symptoms of gout;
3. treatment of patients with recurrent uric acid stone formation;
4. prophylactic treatment to prevent tissue urate deposition, renal calculi, or uric acid nephropathy in patients with leukemias, lymphomas and malignancies who are receiving cancer chemotherapy with its resultant elevating effect on serum uric acid levels.

CONTRAINDICATIONS: Use in children with the exception of those with hyperuricemia secondary to malignancy. The drug should not be employed in nursing mothers.

Patients who have developed a severe reaction to Zyloprim should not be restarted on the drug.

WARNINGS: ZYLOPRIM SHOULD BE DISCONTINUED AT THE FIRST APPEARANCE OF SKIN RASH OR ANY SIGN OF ADVERSE REACTION. In some instances a skin rash may be followed by more severe hypersensitivity reactions such as exfoliative, urticarial and purpuric lesions as well as Stevens-Johnson syndrome (erythema multiforme) and very rarely a generalized vasculitis which may lead to irreversible hepatotoxicity and death.

A few cases of reversible clinical hepatotoxicity have been noted and in some patients asymptomatic rises in serum alkaline phosphatase or serum transaminase have been observed. Accordingly, periodic liver function tests should be performed during the early stages of therapy, particularly in patients with pre-existing liver disease.

Patients should be alerted to the need for due precautions when engaging in activities where alertness is mandatory.

Nevertheless, iron salts should not be given simultaneously with Zyloprim. This drug should not be administered to immediate relatives of patients with idiopathic hemochromatosis.

In patients receiving Purinethol® (mercaptopurine) or Imuran® (azathioprine), the concomitant administration of 300-600 mg of Zyloprim per day will require a reduction in dose to approximately one-third to one-fourth of the usual dose of mercaptopurine or azathioprine. Subsequent adjustment of doses of Purinethol or Imuran should be made on the basis of therapeutic response and any toxic effects.

Usage in Pregnancy and Women of Childbearing Age: Zyloprim® (allopurinol) should be used in pregnant women or women of childbearing age only if the potential benefits to the patient are weighed against the possible risk to the fetus.

PRECAUTIONS: Some investigators have reported an increase in acute attacks of gout during the early stages of allopurinol administration, even when normal or subnormal serum uric acid levels have been attained.

It has been reported that allopurinol prolongs the half-life of the anticoagulant, dicumarol. This interaction should be kept in mind when allopurinol is given to patients already on anticoagulant therapy, and the coagulation time should be reassessed.

A fluid intake sufficient to yield a daily urinary output of at least 2 liters and the maintenance of a neutral or, preferably, slightly alkaline urine are desirable to (1) avoid the theoretic possibility of formation of xanthine calculi under the influence of Zyloprim therapy and (2) help prevent renal precipitation of urates in patients receiving concomitant uricosuric agents.

Patients with impaired renal function require less drug and should be carefully observed during the early stages of Zyloprim administration and the drug withdrawn if increased abnormalities in renal function appear.

In patients with severely impaired renal function, or decreased urate clearance, the half-life of oxipurinol in the plasma is greatly prolonged. Therefore, a dose of 100 mg per day or 300 mg twice a week, or perhaps less, may be sufficient to maintain adequate xanthine oxidase inhibition to reduce serum urate levels. Such patients should be treated with the lowest effective dose, in order to minimize side effects.

Mild reticulocytosis has appeared in some patients.

As with all new agents, periodic determination of liver and kidney function and complete blood counts should be performed especially during the first few months of therapy.

ADVERSE REACTIONS:

Dermatologic: Because in some instances skin rash has been followed by severe hypersensitivity reactions, it is recommended that therapy be discontinued at the first sign of rash or other adverse reaction (see WARNINGS). Skin rash, usually maculopapular, is the adverse reaction most commonly reported.
Exfoliative, urticarial and purpuric lesions, Stevens-Johnson syndrome (erythema multiforme) and toxic epidermal necrolysis have also been reported.
A few cases of alopecia with and without accompanying dermatitis have been reported.
In some patients with a rash, restarting Zyloprim (allopurinol) therapy at lower doses has been accomplished without untoward incident.

Gastrointestinal: Nausea, vomiting, diarrhea, and intermittent abdominal pain have been reported.

Vascular: There have been rare instances of a generalized hypersensitivity vasculitis or necrotizing angiitis which have led to irreversible hepatotoxicity and death.

Hematopoietic: Agranulocytosis, anemia, aplastic anemia, bone marrow depression, leukopenia, pancytopenia and thrombocytopenia have been reported in patients, most of whom received concomitant drugs with potential for causing these reactions. Zyloprim® (allopurinol) has been neither implicated nor excluded as a cause of these reactions.

Neurologic: There have been a few reports of peripheral neuritis occurring while patients were taking Zyloprim. Drowsiness has also been reported in a few patients.

Ophthalmic: There have been a few reports of cataracts found in patients receiving Zyloprim. It is not known if the cataracts predated the Zyloprim therapy. "Toxic" cataracts were reported in one patient who also received an anti-inflammatory agent; again, the time of onset is unknown. In a group of patients followed by Gutman and Yü for up to five years on Zyloprim therapy, no evidence of ophthalmologic effect attributable to Zyloprim was reported.

Drug Idiosyncrasy: Symptoms suggestive of drug idiosyncrasy have been reported in a few patients. This was characterized by fever, chills, leukopenia or leukocytosis, eosinophilia, arthralgias, skin rash, pruritus, nausea and vomiting.

OVERDOSAGE: Massive overdosing, or acute poisoning, by Zyloprim has not been reported.

HOW SUPPLIED: 100 mg (white) scored tablets, bottles of 100 and 1000; 300 mg (peach) scored tablets, bottles of 30, 100 and 500. Unit dose packs for each strength also available.

Complete information available from your local B. W. Co. Representative or from Professional Services Department PML.

U.S. Patent No. 3,624,205 (Use Patent)

Wellcome

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Does it influence your choice of a peripheral/cerebral vasodilator*?

- Vasodilan—compatible with coexisting diseases
- Vasodilan—compatible with concomitant therapy
- Vasodilan—compatible with your total regimen for vascular insufficiency

***Indications:** Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, the FDA has classified the indications as follows:

Possibly Effective:

1. For the relief of symptoms associated with cerebral vascular insufficiency.
2. In peripheral vascular disease of arteriosclerosis obliterans, thromboangiitis obliterans (Buerger's Disease) and Raynaud's disease.

Final classification of the less-than-effective indications requires further investigation.

Composition: Vasodilan tablets, isoxsuprine HCl, 10 mg. and 20 mg.

Vasodilan injection, isoxsuprine HCl, 5 mg., per ml.

Dosage and Administration: Oral: 10 to 20 mg., three or four times daily.

Intramuscular: 5 to 10 mg. (1 or 2 ml.) two or three times daily. Intramuscular administration may be used initially in severe or acute conditions.

Contraindications and Cautions: There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding.

Parenteral administration is not recommended in the presence of hypotension or tachycardia.

Intravenous administration should not be given because of increased likelihood of side effects.

Adverse Reactions: On rare occasions oral administration of the drug has been associated in time with the occurrence of hypotension, tachycardia, nausea, vomiting, dizziness, abdominal distress, and severe rash. If rash appears the drug should be discontinued.

Although available evidence suggests a temporal association of these reactions with isoxsuprine, a causal relationship can be neither confirmed nor refuted.

Administration of single dose of 10 mg. intramuscularly may result in hypotension and tachycardia. These symptoms are more pronounced in higher doses. For these reasons single intramuscular doses exceeding 10 mg. are not recommended. Repeated administration of 5 to 10 mg. intramuscularly at suitable intervals may be employed.

Supplied: Tablets, 10 mg., bottles of 100, 1000, 5000 and Unit Dose; Tablets, 20 mg., bottles of 100, 500, 1000, 5000 and Unit Dose; Injection, 10 mg. per 2 ml. ampul, box of six 2 ml. ampuls.

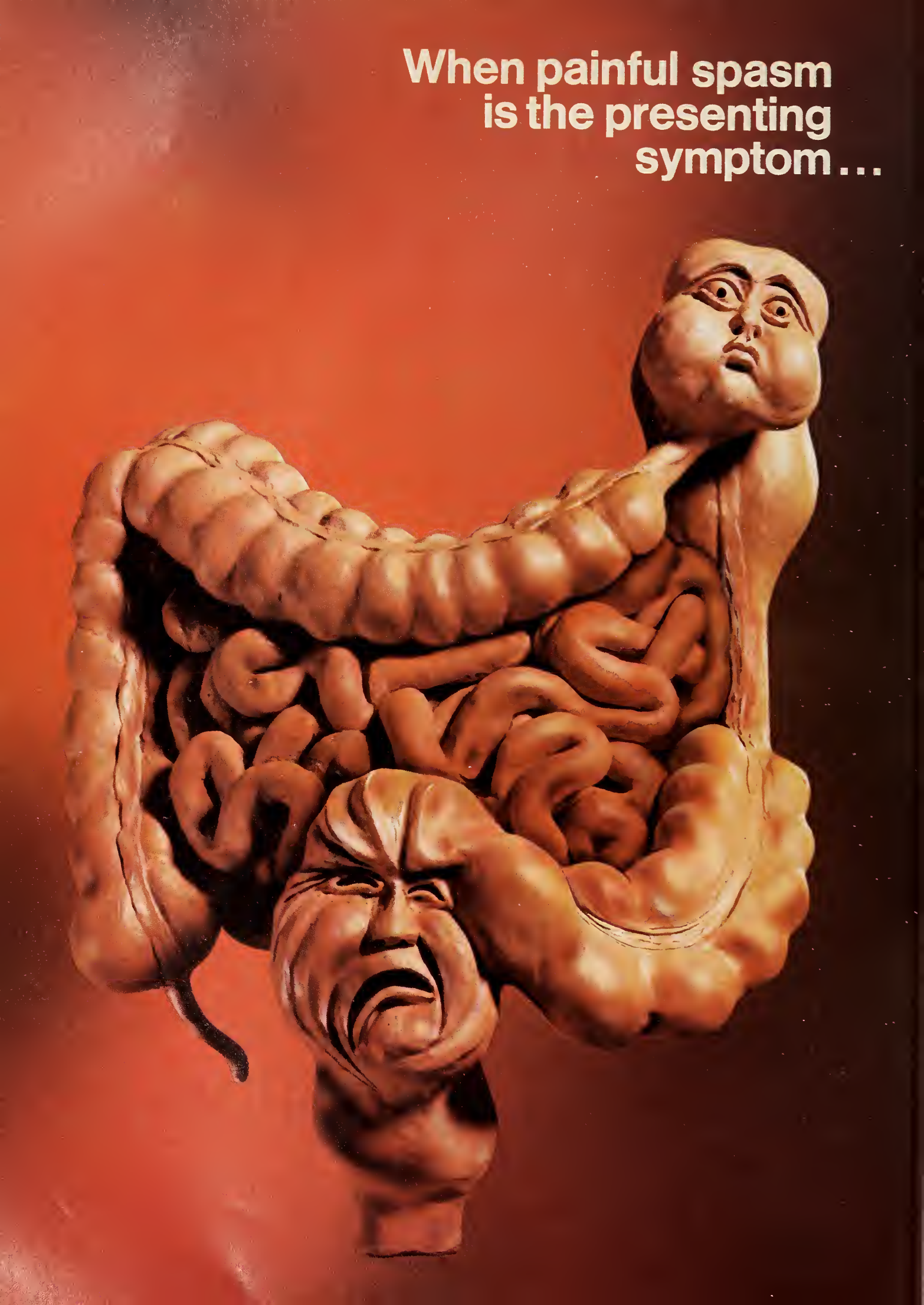
U.S. Pat. No. 3,056,836

VASODILAN®
(ISOXSUPRINE HCl)
20-mg tablets

Mead Johnson PHARMACEUTICAL DIVISION

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When painful spasm is the presenting symptom...



...in the functional bowel/irritable bowel syndrome*

Bentyl®

(dicyclomine hydrochloride USP)

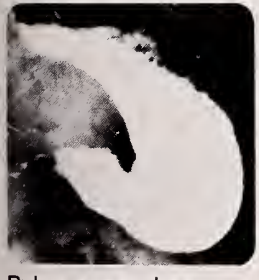
10 mg. capsules, 20 mg. tablets,
10 mg./5 ml. syrup, 10 mg./ml. injection

helps control abnormal motor activity with minimal anticholinergic side effects†

Demonstrated smooth muscle relaxant activity.

In this double-blind study, twenty patients having G.I. series and exhibiting spasm were randomly selected to receive either 2 cc. of Bentyl or sodium chloride intramuscularly. Ten minutes after the injection another radiograph was taken . . .

. . . Bentyl produced definite relaxation in 8 of 10 patients. The sodium chloride produced relaxation in only 3 of 10. No side effects occurred in either group of patients.



Pylorospasm has almost totally blocked passage of barium meal.



Barium meal beginning to pass 10 minutes after intramuscular injection of 20 mg. Bentyl.

"The correlation of spasm relief and drug given was excellent."

*This drug has been classified "probably" effective in treating functional bowel/irritable bowel syndrome.

†See Warnings, Precautions and Adverse Reactions.

See following page for prescribing information.

Reference:
King, J.C. and Starkman, N.M.: Evaluation of an antispasmodic. Double-blind evaluation to control gastrointestinal spasms occurring during radiographic examination. A preliminary report. Western Med. 5:356-358, 1964.

Merrell

8-4420 (Y736A) MNR-804

Bentyl®

(dicyclomine hydrochloride USP)

Capsules, Tablets, Syrup, Injection

AVAILABLE ONLY ON PRESCRIPTION

Brief Summary

INDICATIONS

Based on a review of this drug by the National Academy of Sciences–National Research Council and/or other information, FDA has classified the following indications as "probably" effective:

For the treatment of functional bowel/irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis.

THESE FUNCTIONAL OISORDERS ARE OFTEN RELIEVED BY VARYING COMBINATIONS OF SEDATIVE, REASSURANCE, PHYSICIAN INTEREST, AMELIDRATION OF ENVIRONMENTAL FACTORS.

For use in the treatment of infant colic (syrup).

Final classification of the less-than-effective indications requires further investigation.

CONTRAINOICATIONS: Obstructive uropathy (for example, bladder neck obstruction due to prostatic hypertrophy); obstructive disease of the gastrointestinal tract (as in achalasia, pyloroduodenal stenosis); paralytic ileus, intestinal atony of the elderly or debilitated patient; unstable cardiovascular status in acute hemorrhage; severe ulcerative colitis; toxic megacolon complicating ulcerative colitis; myasthenia gravis. WARNINGS: In the presence of a high environmental temperature, heat prostration can occur with drug use (fever and heat stroke due to decreased sweating). Oiarrhea may be an early symptom of incomplete intestinal obstruction, especially in patients with ileostomy or colostomy. In this instance treatment with this drug would be inappropriate and possibly harmful. Bentyl may produce drowsiness or blurred vision. In this event, the patient should be warned not to engage in activities requiring mental alertness such as operating a motor vehicle or other machinery or perform hazardous work while taking this drug. PRECAUTIONS: Although studies have failed to demonstrate adverse effects of dicyclomine hydrochloride in glaucoma or in patients with prostatic hypertrophy, it should be prescribed with caution in patients known to have or suspected of having glaucoma or prostatic hypertrophy. Use with caution in patients with: Autonomic neuropathy. Hepatic or renal disease. Ulcerative colitis. Large doses may suppress intestinal motility to the point of producing a paralytic ileus and the use of this drug may precipitate or aggravate the serious complication of toxic megacolon. Hyperthyroidism, coronary heart disease, congestive heart failure, cardiac arrhythmias, and hypertension. Hiatal hernia associated with reflux esophagitis since anticholinergic drugs may aggravate this condition.

Do not rely on the use of the drug in the presence of complication of biliary tract disease. Investigate any tachycardia before giving anticholinergic (atropine-like) drugs since they may increase the heart rate. With overdosage, a curare-like action may occur. ADVERSE REACTIONS: Anticholinergics/antispasmodics produce certain effects which may be physiologic or toxic depending upon the individual patient's response. The physician must delineate these. Adverse reactions may include xerostomia; urinary hesitancy and retention; blurred vision and tachycardia; palpitations; mydriasis; cycloplegia; increased ocular tension; loss of taste; headache; nervousness; drowsiness; weakness; dizziness; insomnia; nausea; vomiting; impotence; suppression of lactation; constipation; bloated feeling; severe allergic reaction or drug idiosyncrasies including anaphylaxis; urticaria and other dermal manifestations; some degree of mental confusion and/or excitement, especially in elderly persons; and decreased sweating. With the injectable form there may be a temporary sensation of lightheadedness and occasionally local irritation. DOSAGE AND AOMINISTRATION: Oosage must be adjusted to individual patient's needs.

Usual Dosage: Bentyl 10 mg. capsule and syrup: *Adults:* 1 or 2 capsules or teaspoonfuls syrup three or four times daily. *Children:* 1 capsule or teaspoonful syrup three or four times daily. *Infants:* ½ teaspoonful syrup three or four times daily. (May be diluted with equal volume of water.) Bentyl 20 mg.: *Adults:* 1 tablet three or four times daily. Bentyl Injection: *Adults:* 2 ml. (20 mg.) every four to six hours intramuscularly only. NOT FOR INTRAVENOUS USE. MANAGEMENT OF OVEROOSE: The signs and symptoms of overdose are headache, nausea, vomiting, blurred vision, dilated pupils, hot, dry skin, dizziness, dryness of the mouth, difficulty in swallowing, CNS stimulation. Treatment should consist of gastric lavage, emetics, and activated charcoal. Barbiturates may be used either orally or intramuscularly for sedation but they should not be used if Bentyl with Phenobarbital has been ingested. If indicated, parenteral cholinergic agents such as Urecholine® (bethanecol chloride USP) should be used.

Product Information as of October, 1978.

Injectable dosage forms manufactured by CONNAUGHT LABORATORIES, INC., Swiftwater, Pennsylvania 18370 or TAYLOR PHARMACAL COMPANY, Decatur, Illinois 62525 for MERRELL-NATIDNAL LABORATORIES, Division of Richardson-Merrell Inc., Cincinnati, Ohio 45215, U.S.A.

Merrell

MERRELL-NATIONAL LABORATORIES
Division of Richardson-Merrell Inc.
Cincinnati, Ohio 45215, U.S.A

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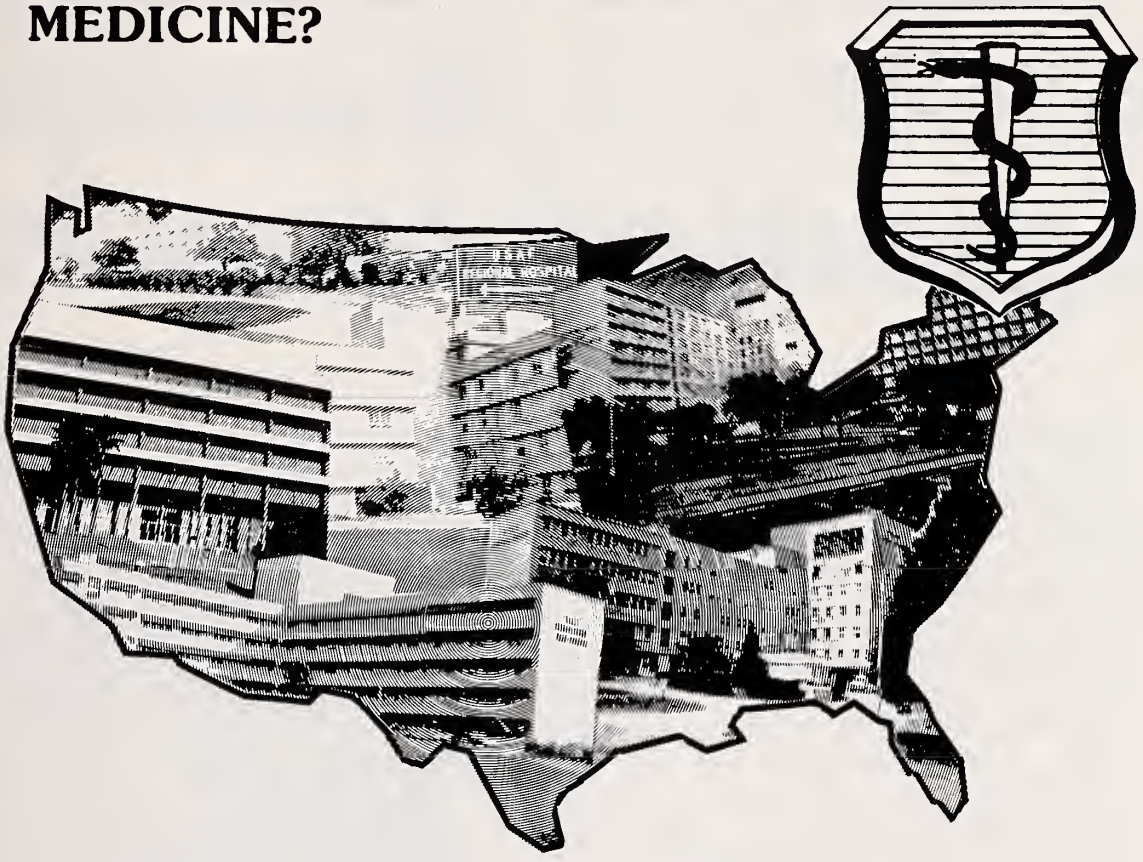
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The professional staff consists of nurses, social workers, recreational therapists, occupational therapists, an art therapist, a music therapist, dance therapist, teachers and counselors.



PHYSICAL FACILITIES:
Located on 37 acres of rolling, wooded land just north of I-285 in DeKalb County, the hospital is near the Shallowford Community Hospital which provides medical support for Peachford Hospital. Peachford is equipped with an X-ray department, a laboratory, emergency treatment room, auditorium/gymnasium, adolescent and children's schools, group therapy rooms, occupational therapy shop, year-round swimming pool and athletic fields for volley ball, tennis, basketball, and badminton.

Peachford Hospital is owned by Charter Medical Corporation, Macon, Georgia. Each service is fully accredited by the Joint Commission on the Accreditation of Hospitals.

ete information or a personal tour of the facilities and explanation of programs, contact:

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Also for the treatment of documented *Pneumocystis carinii* pneumonitis. To date, this drug has been tested only in patients 9 months to 16 years of age who were immunosuppressed by cancer therapy.

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Contraindications: Hypersensitivity to trimethoprim or sulfonamides; pregnancy; nursing mothers; infants less than two months of age.

Warnings: Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been associated with sulfonamides. Experience with trimethoprim is much more limited but occasional interference with hematopoiesis has been reported as well as an increased incidence of thrombopenia with purpura in elderly patients on certain diuretics, primarily thiazides. Sore throat, fever, pallor, purpura or jaundice may be early signs of serious blood disorders. Frequent CBC's are recommended; therapy should be discontinued if a significantly reduced count of any formed blood element is noted.

Precautions: Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, severe allergy or bronchial asthma. In patients with glucose-6-phosphate dehydrogenase deficiency, hemolysis, frequently dose-related, may occur. During therapy, maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function.

Adverse Reactions: All major reactions to sulfonamides and trimethoprim are included, even if not reported with Bactrim. *Blood dyscrasias:* Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia. *Allergic reactions:* Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis. *Gastrointestinal reactions:* Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, diarrhea and pancreatitis. *CNS reactions:* Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness. *Miscellaneous reactions:* Drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L. E. phenomenon. Due to certain chemical similarities to some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia in patients; cross-sensitivity with these agents may exist. In rats, long-term therapy with sulfonamides has produced thyroid malignancies.

Dosage: Not recommended for infants less than two months of age.

Urinary Tract Infections: Usual adult dosage—1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 10-14 days.

Recommended dosage for children—8 mg/kg trimethoprim and 40 mg/kg sulfamethoxazole per 24 hours, in two divided doses for 10 days. A guide follows:

Children two months of age or older.

Weight		Dose—every 12 hours	
lbs	kgs	Teaspoonfuls	Tablets
20	9	1 teasp. (5 ml)	½ tablet
40	18	2 teasp. (10 ml)	1 tablet
60	27	3 teasp. (15 ml)	1½ tablets
80	36	4 teasp. (20 ml)	2 tablets or 1 DS tablet

For patients with renal impairment:

Creatinine Clearance (ml/min)	Recommended Dosage Regimen
Above 30	Usual standard regimen
15-30	½ the usual regimen
Below 15	Use not recommended

Pneumocystis carinii pneumonitis: Recommended dosage: 20 mg/kg trimethoprim and 100 mg/kg sulfamethoxazole per 24 hours in equal doses every 6 hours for 14 days. See complete product information for suggested children's dosage table.

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Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Warn patients that mental and/or physical abilities required for tasks such as driving or operating machinery may be impaired, as may be mental alertness in children, and that concomitant use with alcohol or CNS depressants may have an additive effect. Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported.

Usage in Pregnancy: **Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

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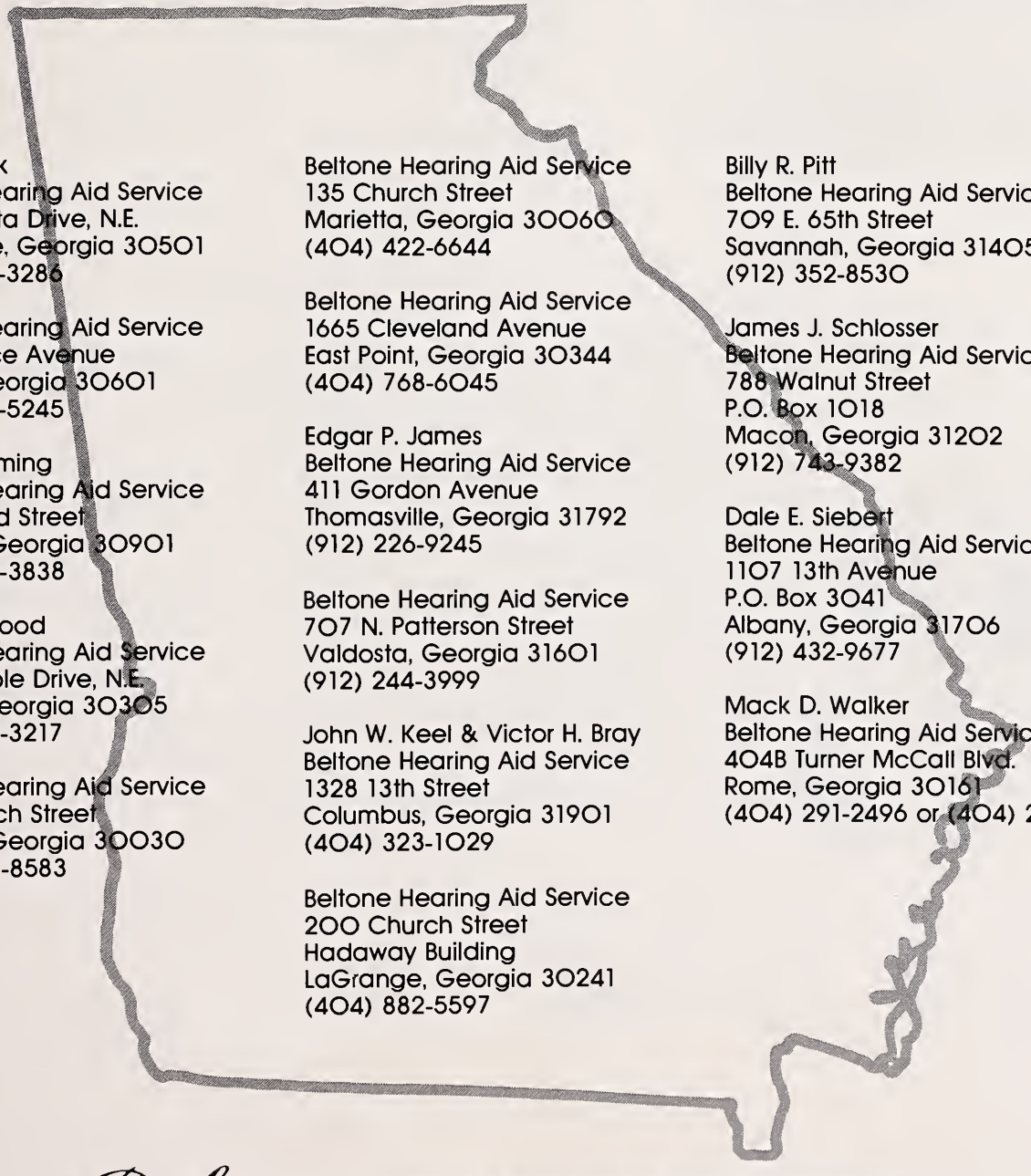
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THE COVER

Our cover this month features research and production aspects of the ethical pharmaceutical industry. Dr. Arthur M. Smith defends this oft-maligned industry in his editorial on p. 478, pointing up the many ways in which it has contributed to our better health and is indeed the keystone for precision therapeutics. Cover design by Richard Lyons.

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17-21—*Sea Island;* **FOURTH ANNUAL SYMPOSIUM ON LUNG DISEASE;** Category 1 credit; Contact: Georgia Lung Assoc., 1383 Spring St., N.W., Atlanta 30309. PH: 404/876-3601.

21-23—*Lake Lanier;* **HYPERTENSION 1979: PRACTICAL MANAGEMENT CONSIDERATIONS FOR THE PHYSICIAN IN CLINICAL PRACTICE;** Category 1 credit; Contact: Dale E. Braddy, American College of Chest Physicians, 911 Busse Hwy., Park Ridge, IL 60068. PH: 312/698-2200.

22-23—*Charleston, SC;* **ANNUAL UPDATE—FAMILY PRACTICE;** Contact: Medical University of South Carolina, 171 Ashley Ave., Charleston, SC 29403.

23-24—*Jekyll Island;* **A SYMPOSIUM ON THE PSYCHOPATHOLOGY OF AGING;** Category 1 credit; Contact: Carl L. Crawford, M.D., Georgia Health Care Medical Directors Assoc., 1410 Russell Pkwy., Warner Robins 31093.

25-28—*Atlanta;* **MEETING, SOCIETY OF NUCLEAR MEDICINE;** Contact: Mrs. M. Glos, 475 Park Ave. South, New York, NY 10016.

25-28—*Orlando, FL;* **OB/GYN EMERGENCIES;** Contact: Dennis K. Wentz, M.D.; University of Tennessee Center for Health Sciences, 62 S. Dunlap St., Memphis, TN 38163. PH: 901/528-5605.

29-30—*Myrtle Beach, SC;* **MEDICAL HORIZONS: HYPERTENSION AND CARDIOVASCULAR DISEASE;** Contact: Emery C. Miller, M.D., Bowman Gray School of Medicine, Winston-Salem, NC 27104.

JULY

10—*Knoxville, TN;* **NEW DEVELOPMENTS IN OPHTHALMOLOGY, INTERNAL MEDICINE;** Category 1 credit; Contact: Knoxville Academy of Medicine, 422 W. Cumberland Ave., Knoxville, TN 37902.

12-13—*Atlanta;* **PHYSICAL IMPAIRMENT AND DISABILITY: ASSESSMENT AND PLACEMENT OF THE SEVERELY DISABLED;** Category 1 credit; Contact: Associate Dean for CME, Emory University School of Medicine, 69 Butler St., S.E., Atlanta 30303. Ph: 404/588-3534.

13-15—*Kissimmee, FL;* **CORONARY DISEASE, EXERCISE TESTING AND CARDIAC REHABILITATION;** Contact: International Medical Education Corp., 64 Inverness Dr. East, Englewood, CO 80110.

15-18—*Lexington, KY;* **THE PROCESS OF HEALTH SCIENCE EDUCATION: PAST, PRESENT AND FUTURE;** Contact: Norm Tucker, Health Education Media Assoc., P.O. Box 771, Riverdale 30274. PH: 404/997-0449.

16-20—*Jekyll Island;* **TAXES AND INVESTMENTS;** Category 1 credit; Contact: Division of Continuing Education, Medical College of Georgia, Augusta 30901. PH: 404/828-3967.

17-18—*Atlanta;* **MEDICAL OFFICE MANAGEMENT INSTITUTE;** Contact: Conomikes Associates, Inc., 4270 Promenade Way, Ste. 122, Marina del Rey, CA 90291. PH: 800/421-6512.

22-27—*Durham, NC;* **SUMMER INSTITUTE OF ALCOHOL STUDIES:** Contact: Fritz Anlyan, 06B West Duke Bldg., Duke University, Durham, NC 27708.

25-29—*Hilton Head Island, SC;* **CONTEMPORARY CLINICAL NEUROLOGY;** Category 1 credit; Contact: Vanderbilt Continuing Education, 305 Medical Arts Bldg., Nashville, TN 37212. PH: 615/322-2716.

29-August 2—*Atlanta;* **21ST ANNUAL MEETING AND EXHIBITION, AMERICAN ASSOCIATION OF PHYSICISTS IN MEDICINE;** Contact: Sharon Pierce, American Assoc. of Physicists in Medicine, 111 E. Wacker Dr., Chicago, IL 60610. PH: 312/644-6610.

AUGUST

2-3—*Atlanta;* **COPING WITH THE PSYCHOLOGICAL ASPECTS OF DISEASE AND DISABILITY:** Category 1 credit; Contact: Associate Dean for CME, Emory University School of Medicine, 69 Butler St., S.E., Atlanta 30303. PH: 404/588-3534.

2-6—*Orlando, FL;* **DIAGNOSTIC IMAGING OF THE HEART;** Category 1 credit; Contact: Lawrence R. Muroff, M.D., Educational Symposia, P.O. Box 17241, Tampa, FL 33682.

6-8—*Kiawah Island, SC;* **PEDIATRIC UPDATE 1979;** Category 1 credit; Contact: Division of Continuing Education, Medical College of Georgia, Augusta 30901. PH: 404/828-3967.

14—*Knoxville, TN;* **NEW DEVELOPMENTS IN EMERGENCY MEDICINE, UROLOGY, FAMILY PRACTICE, PSYCHIATRY;** Category 1 credit; Contact: Knoxville Academy of Medicine, 422 W. Cumberland Ave., Knoxville, TN 37902.

17-19—*Kissimmee, FL;* **CLINICAL ECG ARRHYTHMIA MANAGEMENT;** Contact: International Medical Education Corp., 64 Inverness Dr. East, Englewood, CO 80110.

24-26—*Hilton Head Island, SC;* **CARDIAC SYMPTOMS AND ARRHYTHMIAS;** Contact: International Medical Education Corp., 64 Inverness Dr. East, Englewood, CO 80110.

27-31—*Nashville, TN;* **TEMPORAL BONE SURGICAL DISSECTION;** Category 1 credit; Contact: Education Auditory Research Foundation, 2000 Church St., Nashville, TN 37236.

For additional information on these and other meetings, contact MAG, Division of Education 404/876-7535

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PRECAUTIONS: As with other antibacterial preparations, prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs.

ADVERSE REACTIONS: Neomycin is a not uncommon cutaneous sensitizer. Articles in the current literature indicate an increase in the prevalence of persons allergic to neomycin. Ototoxicity and nephrotoxicity have been reported (see Warning section).

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CONTRAINDICATIONS: Central nervous system depression from drugs (barbiturates, alcohol, narcotics, analgesics, antihistamines); evidence of bone marrow depression; known hypersensitivity to phenothiazines or amitriptyline. Should not be given concomitantly with a monoamine oxidase inhibitor since hyperpyretic crises, severe convulsions, and deaths have occurred from such combinations. When used to replace a monoamine oxidase inhibitor, allow a minimum of 14 days to elapse before initiating therapy with TRIAVIL. Therapy should then be initiated cautiously with gradual increase in dosage until optimum response is achieved. Not recommended for use during acute recovery phase following myocardial infarction.

WARNINGS: TRIAVIL should not be given concomitantly with guanethidine or similarly acting compounds since TRIAVIL may block the antihypertensive action of such compounds. Use cautiously in patients with history of urinary retention, angle-closure glaucoma, increased intraocular pressure, or convulsive disorders. Dosage of anticonvulsive agents may have to be increased. In patients with angle-closure glaucoma, even average doses may precipitate an attack. Patients with cardiovascular disorders should be watched closely. Tricyclic antidepressants, including amitriptyline HCl, have been reported to produce arrhythmias, sinus tachycardia, and prolongation of conduction time, particularly in high doses. Myocardial infarction and stroke have been reported with tricyclic antidepressant drugs. Close supervision is required for hyperthyroid patients or those receiving thyroid medication. May impair mental and/or physical abilities required for performance of hazardous tasks, such as operating machinery or driving a motor vehicle. In patients who use alcohol excessively, potentiation may increase the danger inherent in any suicide attempt or overdosage. Not recommended in children or during pregnancy.

PRECAUTIONS: Suicide is a possibility in depressed patients and may remain until significant remission occurs. Such patients should not have access to large quantities of this drug.

Perphenazine: Should not be used indiscriminately. Use with caution in patients who have previously exhibited severe adverse reactions to other phenothiazines. Likelihood of some untoward actions is greater with high doses. Closely supervise with any dosage. The antiemetic effect of perphenazine may obscure signs of toxicity due to overdosage of other drugs or make more difficult the diagnosis of disorders such as brain tumor or intestinal obstruction. A significant, not otherwise explained, rise in body temperature may suggest individual intolerance to perphenazine, in which case discontinue.

If hypotension develops, epinephrine should not be employed, as its action is blocked and partially reversed by perphenazine. Phenothiazines may potentiate the action of central nervous system depressants (opiates, analgesics, antihistamines, barbiturates, alcohol) and atropine. In concurrent therapy with any of these, TRIAVIL should be given in reduced dosage. May also potentiate the action of heat and phosphorous insecticides. There is sufficient experimental evidence to conclude that chronic administration of antipsychotic drugs which increase prolactin secretion has the potential to induce mammary neoplasms in rodents under the appropriate conditions. There are recognized differences in the physiological role of prolactin between rodents and humans. Since there are, at present, no adequate epidemiological studies, the relevance to human mammary cancer risk from prolonged exposure to perphenazine and other antipsychotic drugs is not known.

Amitriptyline: In manic-depressive psychosis, depressed patients may experience a shift toward the manic phase if they are treated with an antidepressant. Patients with paranoid symptomatology may have an exaggeration of such symptoms. The tranquilizing effect of TRIAVIL seems to reduce the likelihood of this effect. When amitriptyline HCl is given with anticholinergic agents or sympathomimetic drugs, including epinephrine combined with local anesthetics, close supervision and careful adjustment of dosages are required. Paralytic ileus may occur in patients taking tricyclic antidepressants in combination with anticholinergic-type drugs.

Caution is advised if patients receive large doses of ethchlorvynol concurrently. Transient delirium has been reported in patients who were treated with 1 g of ethchlorvynol and 75-150 mg of amitriptyline HCl.

Amitriptyline HCl may enhance the response to alcohol and the effects of barbiturates and other CNS depressants.

Concurrent administration of amitriptyline HCl and electroshock therapy may increase the hazards associated with such therapy. Such treatment should be limited to patients for whom it is essential. Discontinue several days before elective surgery if possible. Elevation and lowering of blood sugar levels have both been reported. Use with caution in patients with impaired liver function.

ADVERSE REACTIONS: Similar to those reported with either constituent alone.
Perphenazine: Extrapyramidal symptoms (opisthotonus, oculogyric crisis, hyperreflexia, dystonia, akathisia, acute dyskinesia, ataxia, parkinsonism) have been reported and can usually be controlled by the concomitant use of effective antiparkinsonian drugs and/or by reduction in dosage, but sometimes persist after discontinuation of the phenothiazine.

Tardive dyskinesia may appear in some patients on long-term therapy or may occur after drug therapy with phenothiazines and related agents has been discontinued. The risk appears to be greater in elderly patients on high-dose therapy, especially females. Symptoms are persistent and in some patients appear to be irreversible. The syndrome is characterized by rhythmical involuntary movements of the tongue, face, mouth, or jaw. Involuntary movements of the extremities sometimes occur. There is no known treatment for tardive dyskinesia; antiparkinsonism agents usually do not alleviate the symptoms. It is advised that all antipsychotic agents be discontinued if the above symptoms appear. If treatment is reinstituted, or dosage of the particular drug increased, or another drug substituted, the syndrome may be masked. Fine vermicular movements of the tongue may be an early sign of the syndrome. The full-blown syndrome may not develop if medication is stopped when lingual vermiculation appears.

Other side effects are skin disorders (photosensitivity, itching, erythema, urticaria, eczema, up to exfoliative dermatitis); other allergic reactions (asthma, laryngeal edema, angioneurotic edema, anaphylactoid reactions); peripheral edema; reversed epinephrine effect; hyperglycemia; endocrine disturbances (lactation, galactorrhea, gynecomastia, disturbances of menstrual cycle); altered cerebrospinal fluid proteins; paradoxical excitement; hypertension, hypotension, tachycardia, and ECG abnormalities (quinidine-like effect); reactivation of psychotic processes; catatonic-like states; autonomic reactions, such as dry mouth or salivation, headache, anorexia, nausea, vomiting, constipation, obstipation, urinary frequency or incontinence, blurred vision, nasal congestion, and a change in pulse rate; other adverse reactions reported with various phenothiazine compounds, but not with perphenazine, include grand mal convulsions, cerebral edema, polyphagia, pigmentary retinopathy, photophobia, skin pigmentation, and failure of ejaculation.

The phenothiazine compounds have produced blood dyscrasias (pancytopenia, thrombocytopenic purpura, leukopenia, agranulocytosis, eosinophilia); and liver damage (jaundice, biliary stasis).

Pigmentation of the cornea and lens has been reported to occur after long-term administration of some phenothiazines. Although it has not been reported in patients receiving TRIAVIL, the possibility that it might occur should be considered.

Hypnotic effects, lassitude, muscle weakness, and mild insomnia have also been reported.

Amitriptyline: Note: Listing includes a few reactions not reported for this drug, but which have occurred with other pharmacologically similar tricyclic antidepressant drugs and must be considered when amitriptyline is administered. *Cardiovascular:* Hypotension; hypertension; tachycardia; palpitation; myocardial infarction; arrhythmias; heart block; stroke. *CNS and Neuromuscular:* Confusional states; disturbed concentration; disorientation; delusions; hallucinations; excitement; anxiety; restlessness; insomnia; nightmares; numbness, tingling, and paresthesias of the extremities; peripheral neuropathy; incoordination; ataxia; tremors; seizures; alteration in EEG patterns; extrapyramidal symptoms; tinnitus; syndrome of inappropriate ADH (antidiuretic hormone) secretion. *Anticholinergic:* Dry mouth; blurred vision; disturbance of accommodation; increased intraocular pressure; constipation; paralytic ileus; urinary retention; dilatation of urinary tract. *Allergic:* Skin rash; urticaria; photosensitization; edema of face and tongue. *Hematologic:* Bone marrow depression including agranulocytosis; leukopenia; eosinophilia; purpura; thrombocytopenia. *Gastrointestinal:* Nausea; epigastric distress; vomiting; anorexia; stomatitis; peculiar taste; diarrhea; parotid swelling; black tongue. Rarely hepatitis (including altered liver function and jaundice). *Endocrine:* Testicular swelling and gynecomastia in the male; breast enlargement and galactorrhea in the female; increased or decreased libido; elevated or lowered blood sugar levels. *Other:* Dizziness, weakness; fatigue; headache; weight gain or loss; increased perspiration; urinary frequency; mydriasis; drowsiness; alopecia. *Withdrawal Symptoms:* Abrupt cessation after prolonged administration may produce nausea, headache, and malaise. These are not indicative of addiction.

OVERDOSAGE: All patients suspected of having taken an overdosage should be admitted to a hospital as soon as possible. Treatment is symptomatic and supportive. However, the intravenous administration of 1–3 mg of physostigmine salicylate is reported to reverse the symptoms of tricyclic antidepressant poisoning. Because physostigmine is rapidly metabolized, the dosage of physostigmine should be repeated as required particularly if life-threatening signs such as arrhythmias, convulsions, and deep coma recur or persist after the initial dosage of physostigmine. On this basis, in severe overdosage with perphenazine-amitriptyline combinations, symptomatic treatment of central anticholinergic effects with physostigmine salicylate should be considered.

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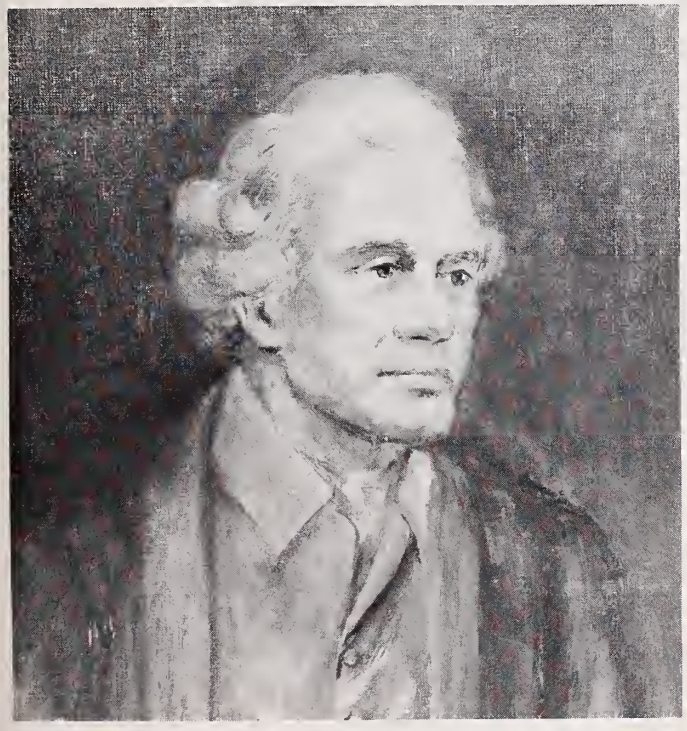
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John Hunter and Two Cherokee Indians

ANTHONY A. PEARSON, M.A., Ph.D., *Portland**



John Hunter (1728-1793). An oil painting (1977) by Emily Maxwell, of Portland, Oregon.

Introduction

A VISITOR ENTERING the Royal College of Surgeons of England for the first time finds himself surrounded with historic personalities in the form of marble busts, statues, and portraits in oils. Here John Hunter is the dominant figure. The hall containing the Hunterian Art Collection[1, 2] immediately captured my own attention. Among these paintings, four were of native Americans. I would have expected to find portraits of men like Benjamin Rush or Benjamin Franklin. To my surprise there was an "Esquimo Woman from Labrador," an "American Indian and Family," and two "Cherokee Indians." My immediate questions were, who were these people and what brought them to London? Under what circumstances did they meet John Hunter, and who painted their portraits? The search for the answers to these questions led to the unfolding of the following story of the two Cherokee Indians (Figures 1 and 2).

The Indians

The two portraits of Cherokee Indians were commissioned by John Hunter and were painted by William Hodges, R.A. in 1790 or 1791. They are referred to in the notes of William Clift,[3] who worked closely with Hunter. According to Clift, the two Cherokees came to England after the American Revolution in which they had fought on the British side. In London, they met John Hunter at a party given by the famous naturalist Sir Joseph Banks who, with Hodges, had accompanied Captain Cook in the *Endeavour* to Australia.

A reference thought to be related to these Indians is in the *Gentlemen's Magazine* dated 19th October 1790: "Arrived in Portsmouth, the *Lord Dorchester*, merchantman from Quebec. In her came passengers, some Indians, said to be Cherokees, the object of whose mission is not generally known." In December of the same year another notice, also in the *Gentlemen's Magazine*, mentioned three Indians from Quebec in the company of an English officer. The *Gloucester Journal* on 1st November 1790 reported two men in Indian dress with many feathers and painted with vermilion about the ears. One of

* Dr. Pearson is Professor Emeritus of Anatomy, University of Oregon Health Sciences Center, School of Medicine, Portland, Oregon. His address is University of Oregon Medical School, Portland, OR 97201. Reprinted from *Annals of the Royal College of Surgeons of England*, Vol. 58, September 1976.



Figure 1 — Cherokee Indian (RCS, Hunterian Collection, No. 245). Oil on canvas, by William Hodges, R.A., unsigned. This Indian wears a dark blue blanket with red and yellow braids over a white frilled shirt with a black neckcloth. On his chest is a silver gorget. He has silver wheel earrings, a silver band on his right arm, and a white feather in his hair.

them was described as a handsome Englishman who had lived with the Creek Indians for many years. According to the *Kentish Gazette* there were six visitors, two of whom were chiefs and one an Englishman named Bowles. Since they were all dressed like Indians, Bowles was often mistaken for an Indian. Lord Dorchester was said to have arranged for the passage of six Indians sailing from Canada, three Creeks, and three Cherokees. Their mission appears to have been concerned with problems related to the Spanish along the Gulf of Mexico.[4-6]

Information gathered from a number of sources[3-6] about the two Cherokee Indians whose portraits are in the Hunterian Collection suggests that they were the Cherokee chiefs who accompanied W. A. Bowles to London in the autumn of 1790, and the date of the painting of these portraits coincide with the time of the visit of Bowles to London. Their white shirts with ruffles and their silver gorgets and arm bands closely resemble those in the portrait of Bowles painted by Thomas Hardy during this same period. Engravings of his portrait (Figure 3) are preserved in the British Museum in London and the National Portrait Gallery in Washington, D.C. Ornaments similar to the silver gorgets, arm bands, and ear pendants shown in these portraits can be seen in exhibits at the Museum of the American Indian in New York City.

Attention is called to the ears of the Cherokee in the portrait shown in Figure 2. Each ear lobe, from which a silver wheel-like ornament hangs, has a hole large enough to pass one or two fingers. It was not unusual for these Indians to pierce their ear lobes with a scalping knife and to stretch the rim of each ear, making the opening larger. Henry Timberlake[7] lived with the Cherokee Indians for a period and he described this practice in his *Memoirs*. The procedure was said to be so painful that one ear was pierced and allowed to heal before the other ear received similar treatment.



Figure 2 — Cherokee Indian (RCS, Hunterian Collection, No. 246). Oil on canvas, by William Hodges, R.A., unsigned. A companion portrait to No. 245, of a different sitter in similar attitude and dress but without the feather in his hair.

William Bowles

In order to understand the significance of the two Cherokee Indians in the Hunterian Collection, one must examine the life story of Bowles.[4, 5, 8] William Augustus Bowles was born on the Maryland frontier in 1763. He was described as a handsome youth with an olive complexion. The War of the American Revolution changed the course of his life. William's father refused to support the cause for American independence, and this made him a Loyalist. William became indignant over insults to his family and volunteered to fight for the British King. He joined the British Army in Philadelphia and was sent to Florida. Here he found himself in trouble and was discharged. At the age of 16 years he was alone in a strange country. The Creek Indians were kind to him and invited him to their village. He lived with these Indians for several months and married the daughter of an Indian chief. Later he rejoined the British Army in Florida, and in 1780 he distinguished himself in a battle with the Spanish. (At this time Spain occupied Florida, and there were occasional skirmishes between the British and Spanish forces.) His military service in Florida ended when General Campbell surrendered the Maryland Loyalists to the Spaniards. Bowles and other prisoners were sent to Havana and then to New York. When Bowles went to Florida he was a confused boy; now he was a man. Soon after William reached New York, General Cornwallis surrendered, and the war was over. For Loyalists to stay in New York was an unattractive future, and few remained; they feared reprisals and many of them went to Canada. Bowles went to the Bahama Islands and eventually to Georgia, where again he lived with the Creek Indians.

Life with the Creek Nation did much to mould his character. He shared their hopes and frustrations. Now he was one of them and he became their "commander-in-chief." Bowles was quick to learn and was well schooled in experience. He was not



Figure 3 — William Augustus Bowles, Chief of the Embassy from the Creek and Cherokee Nations. An engraving of a painting by T. Hardy, 1791, London. Reproduced by courtesy of the National Portrait Gallery, Smithsonian Institution, Washington, D.C.

unlike a chameleon in that he could adapt to any situation. The story of his life often appears to be more romantic than factual. However, one must remember the words of Byron's Don Juan, "Truth is always strange; stranger than fiction."

Creeks and Cherokees

The Creeks were the largest and best organized tribe of Indians in the South. In the years after the Revolution, the Creeks and the Cherokees were hemmed in on the south by the Spanish and pressed on other fronts by American settlers. Bowles was aware of the dilemma of the Indians and offered them his services. The Indians were alarmed in particular by the threats of further Georgia expansion. Bowles, like Tecumseh,[9] had a dream of uniting the Indians in the South with those in the North to form a confederation to stop the American aggression.

Before the Revolution, in 1763, the English and French had signed a treaty[5] placing all the Indians east of the Mississippi River under the jurisdiction of England. The English, through treaties and their Indian agents, had established strong ties with many Indian tribes. As a result, the loyalties of the Indians were more often with the English than with the American colonies. By a Royal Proclamation, George III set forth a policy excluding settlers from territories west of the Appalachian Mountains until the Indians had been pacified. The British government thus attempted to keep the white settlers out of the Indian hunting grounds where they had aroused so much hostility. This put the British in opposition to powerful forces developing in American life which led to the American Revolution.

After the Revolution, the Cherokee Indians made peace with South Carolina, Georgia, and Virginia.[10, 11] These treaties deeded millions of acres of land from the Cherokees to these states, and the Indians were forced from the Piedmont region into the mountain areas west of South Carolina, between

"With more American threats, the Creeks and Cherokees, though not traditional friends, were forced to become allies."

Georgia and Virginia. The Cherokees, in giving up large portions of their lands, hoped for a peace which would be a lasting one. With more American threats the Creeks and Cherokees, though not traditional friends, were forced to become allies. In 1789, the Grand Council of the Creeks selected several chiefs to accompany Bowles to London. Bowles, who was both a chief of the Creek Nation and a British officer on half pay, was given the title of "Director General of the Creek Nation." He was commissioned to go directly to King George III and request that he reaffirm the treaties signed before the Revolutionary War and issue new medals, and also take the southern Indians under his wing as he had done with the Indian tribes north of the Ohio River. Bowles insisted that the southern Indians were still loyal to the English King.[4, 5]

It was during this period that a portrait was painted, perhaps by Bowles himself, showing Bowles in the centre of the picture and a Cherokee chief on either side of him. Under this picture was written: "General Bowles, Commander-in-Chief of the Creek and Cherokee Nations." The names of the two Cherokee Indians in this picture were Richard Justice and Moses Price, and it is likely that they are the Cherokees in the two portraits in the Hunterian Collection in London. Price at one time acted as a Spanish interpreter, and Justice took part in a scalp dance on Lookout Mountain near Chattanooga, Tennessee, and tore up a scalp with his hands and teeth.[6] It is reported that this picture of Bowles and the two Cherokees was in the home of Richard Justice in Knoxville, Tennessee, in 1792; it was displayed among the southern Indians for many years until it was lost.[4, 5]

Mission to England

The first leg of the delegation's journey to London took them to Nassau.[5] A main Indian objective was

to encourage King George to sponsor both the northern and southern Indians through the Canadian Indian Department. In 1789, there was the possibility of an Anglo-Spanish war, and the role that the Creek and Cherokee Indian Nations might play in this was an important one. The cause of the dispute[5] was the "Nootka incident," with the Spanish seizure of four British ships in Nootka Sound on Vancouver

"In 1789, there was the possibility of an Anglo-Spanish war, and the role that the Creek and Cherokee Indian Nations might play . . . was . . . important."

Island on the west coast of Canada. This dispute involved more than the seizure of a few ships. At stake was the ownership of the entire Pacific North-West. War was imminent.

It was therefore decided that Bowles should go from Nassau to Canada and then to England. The delegation consisted of Bowles and five Indians from the Creek and Cherokee Nations. Bowles was pure white and the two Cherokees, Richard Justice and Moses Price, may have been half-breeds. Indians in that period often had several names, and many had English names as well. Bowles was called Eastajaca by the Indians, while the Indian name of one of the Cherokees, said to be "a young man of engaging countenance," was Unatoy. After many months of delay, the Indians landed in Canada. Although they had no official documents to present to Lord Dorchester, the Canadian Governor, they were given lodging, and the Governor provided for their passage to England. The party of Indians finally sailed to England on the merchantman *Dorchester*. They reached Plymouth in October 1790, and with much ceremony Bowles and the Indians were taken ashore. Bowles claimed that twenty thousand Cherokees and Creeks, reinforced by many thousands of Chickasaws and Choctaws, were ready to conquer Florida

"Bowles claimed that 20,000 Cherokees and Creeks, reinforced by . . . Chickasaws and Choctaws, were ready to conquer Florida and Louisiana."

and Louisiana and then march into Mexico. These rumours revived memories of the days of glory with Drake, Hawkins, and Henry Morgan. The Indians were given a few guineas and sent on to London.[4, 5]

In London they were lodged at Osborne's Hotel in the Adelphi, which was close to the Thames and Whitehall. After conferring with minor officials they met the Home Secretary, William Windham Grenville. Grenville was concerned over the possibility of a war with Spain, and he was interested in the potential military usefulness of the southern Indians. At this same time, dissatisfied Vermonters were also in London exploring the possibility of throwing in their lot with Canada in the event that the United States might break in pieces. It was considered logical that the Indians should take their petitions directly to King George III. Early in November of 1790, a short time after their arrival, a time was set for an audience with the King. Distinguished guests arrived, but no Indians came. The reason was soon obvious. The Spanish had capitulated, and there would be no war.[5] The Indian delegation was greatly disappointed; success had seemed to be within their reach and had slipped through their fingers.

There was little reason now for England publicly to recognize these Indians and furnish them with arms. However, even after the crisis had passed the Indians still received a great deal of attention; they were living proof of the concept of the "noble savage" which had been eulogized by Rousseau. They drew crowds wherever they went, in the theatres and at masquerade parties, where their costumes were not only the most authentic but the most original, and they were mentioned often in the news. They introduced a new dish to London gourmets called "Cherokee fricassee."[5]

"Bowles became the Don Juan of London society. He and the Indians had a busy social calendar."

They stayed in London until the spring of 1791. Bowles was especially popular, and he was received by the Prince of Wales, the Duke of Gloucester, Lord Townshend, and many of the nobility. A member of the Townshend family, Lieutenant-Colonel Roger Townshend, had been killed in the French and Indian War in 1759, and the interest of this family in the American Indians is illustrated in the Townshend Memorial in Westminster Abbey; the two Indians carved in stone are considered to be among the best pieces of sculpture in the Abbey.[12]

Bowles became the "Don Juan" of London society. He and the Indians had a busy social calendar. They attended the theatre in Covent Garden and saw performances such as "The Tragedy," "The Provocation," and "The Cherokee." The Indians were painted and dressed to suit the occasion. Both Bowles and the Indians often wore long hunting jackets and buckskin leggings, but while they usually dressed as Indians, at parties they would wear white shirts with ruffles, with a formal cape, knee breeches, and a turban with ostrich feathers. For ornaments they would wear silver arm bands, earrings, and half-moon gorgets. The chiefs would carry ceremonial silver pipe tomahawks, which sig-

nified their rank. They also visited St. Paul's Cathedral and showed much interest in the organ. Bowles attended the lectures of George Pearson at St. George's Hospital, and they became close friends.[5] Hunter also served on the staff at St. George's Hospital, and it seems likely that he knew Bowles.

After the Nootka crisis had passed, there was little reason for Bowles to remain in London. He now requested that Britain help the Creeks and Cherokees in an unofficial manner and arrange a trade agreement between Nassau and the Creek-Cherokee Nation that would bypass the Spanish in Florida. He called the new nation "Muskogee" and represented himself as their Director General. Bowles also negotiated with the Spanish; the Spanish Ambassador entertained him at his residence in Manchester Square, and from time to time he and the Indian chiefs attended formal dinners at the Spanish Embassy.[5]

In the meantime Bowles pointed out to Grenville that British losses in America were great, that one of their remaining trump cards held in America was the southern Indian, and that this should not be lost. It was agreed that Nassau could be open to the Muskogee Nation but that in Florida and Georgia the Indians would be on their own to deal with the Spanish and the Americans. Bowles paid a last visit to Downing Street and returned to America.[5]

Return Home

Bowles had come to England 5 months earlier with high hopes. The Nootka settlement had spoiled everything. In London he had been feted, his portrait and those of two of his companions had been painted, his life story had been published,[8] and he had conferred with the highest British and Spanish diplomats. At 28, he had become an international figure, and he now must look for other worlds to conquer.

Curious crowds of people watched as they left London in two coaches. At Gravesend, where Pocahontas had died in 1617, they boarded the *Mercury,* and after a stop in Nassau they continued in a ship carrying the flag of the Muskogee (Creek) Nation. This flag had a blue cross on a red background and in the upper left-hand corner bore a sun with human features. A face in a blazing sun is a popular motif today. In a recent exhibit in San Francisco, this symbol was illustrated in a book[13] carried by Sir Francis Drake on one of his voyages to the New World.

The Muskogee vessel evaded the Spanish ships and landed in Florida. Here we lose sight of the two Cherokee chiefs in the Hunterian Collection. The complete story of the adventures of Bowles[5] is much too long to be related here. Suffice it to say that he returned to his life with the Indians and eventually was arrested, taken to Spain, and finally to Havana, where he died in a dungeon in Morro Castle in 1805. Had he not been arrested by the Spanish, he probably would have been seized by the Americans.

Afterthoughts

According to Foreman[4] and Wright,[5] it is unlikely that Bowles himself was presented publicly to King George. Higham,[4] however, has listed the names of the five Indians and stated that they addressed the English King on 3rd January 1791. This meeting with the King was not publicized in the London newspapers. While they were entertained by prominent people, they were not officially recognized in the manner that Pocahontas (1616) and the Indian delegations which visited London with Sir Alexander Cuming (1730) and Henry Timberlake (1762) were received. It is hard to believe that John Hunter, who was interested in the whole world around him, was not aware of the nature of the mission on which these Indians were engaged. Unfortunately, many of his notes and records were lost.[14]

"The problem of colonial America in dealing with the Indian may have been among the main causes [leading] to the American Revolution."

The problems of colonial America in dealing with the Indian may have been among the main causes which led to the American Revolution. Indian commissioners like Sir William Johnson[15] had attempted to keep the new settlers away from the Indian hunting grounds. The ministers in Whitehall found themselves in opposition to the aspirations of the hordes of emigrants to the New World. Even colonists like George Washington regarded the King's proclamation of 1763 as a temporary restriction to keep the Indians quiet while the settlers were taking the good lands.[16]

If the Nootka incident had resulted in war with Spain, King George would probably have recognized the Muskogee Creek-Cherokee Nation. If the war with America in 1812 had come as early as 1803, the British would probably have supplied the Creek and Cherokee Indians with guns. The British expedition in the Gulf of Mexico against Louisiana would then have been more likely to succeed. General Andrew Jackson would probably not have been victorious in New Orleans, and the Muskogee Nation would very likely have survived with the status of a Dominion of Great Britain. History relates that many Indians, including Bowles's son,[5] did support the British at the time of the Battle of New Orleans. Fate and Andrew Jackson had other plans for these Indians. The State of Georgia wanted to expel them

and President Jackson coveted the western lands of Georgia for future states — Alabama and Mississippi. In this struggle for land even the Supreme Court of the United States was helpless to intervene.[16] The U.S. Army, under presidential orders, removed many of these Indians to Oklahoma, their march through the wilderness being called the "trail of tears." To use a slang expression, these Indians were "born losers." In the War of the American Revolution, they chose the losing side, and later in the American Civil War many of them fought with the Southern Confederacy. If fate had been different, Bowles would not have ended his days in a Havana prison, and his two Cherokee companions would have ranked as founding fathers of a Muskogee Nation. Here it is interesting to contemplate that in the person of John Hunter these Indians found a sympathetic ear. It has been said that the spirit of John Hunter haunts the galleries of the Royal College of Surgeons of England. Perhaps among these paintings the ghosts of Indians linger still.

I wish to express my gratitude to the late Mr. Norman Capener, F.R.C.S. and to Dr. Donald Crowther, M.R.C.S., for their encouragement during the preparation of this paper. I must also thank the staff of the Royal College of Surgeons of England and its Librarian, Mr. E. H. Cornelius.

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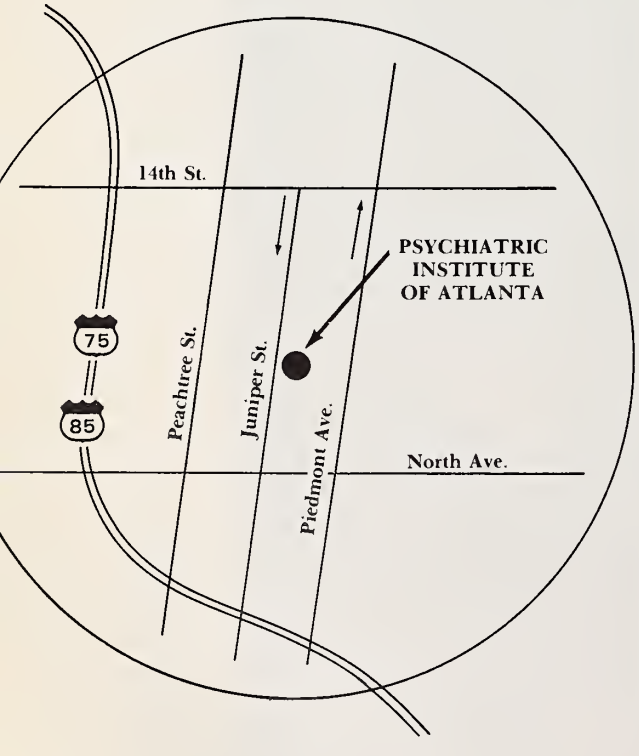
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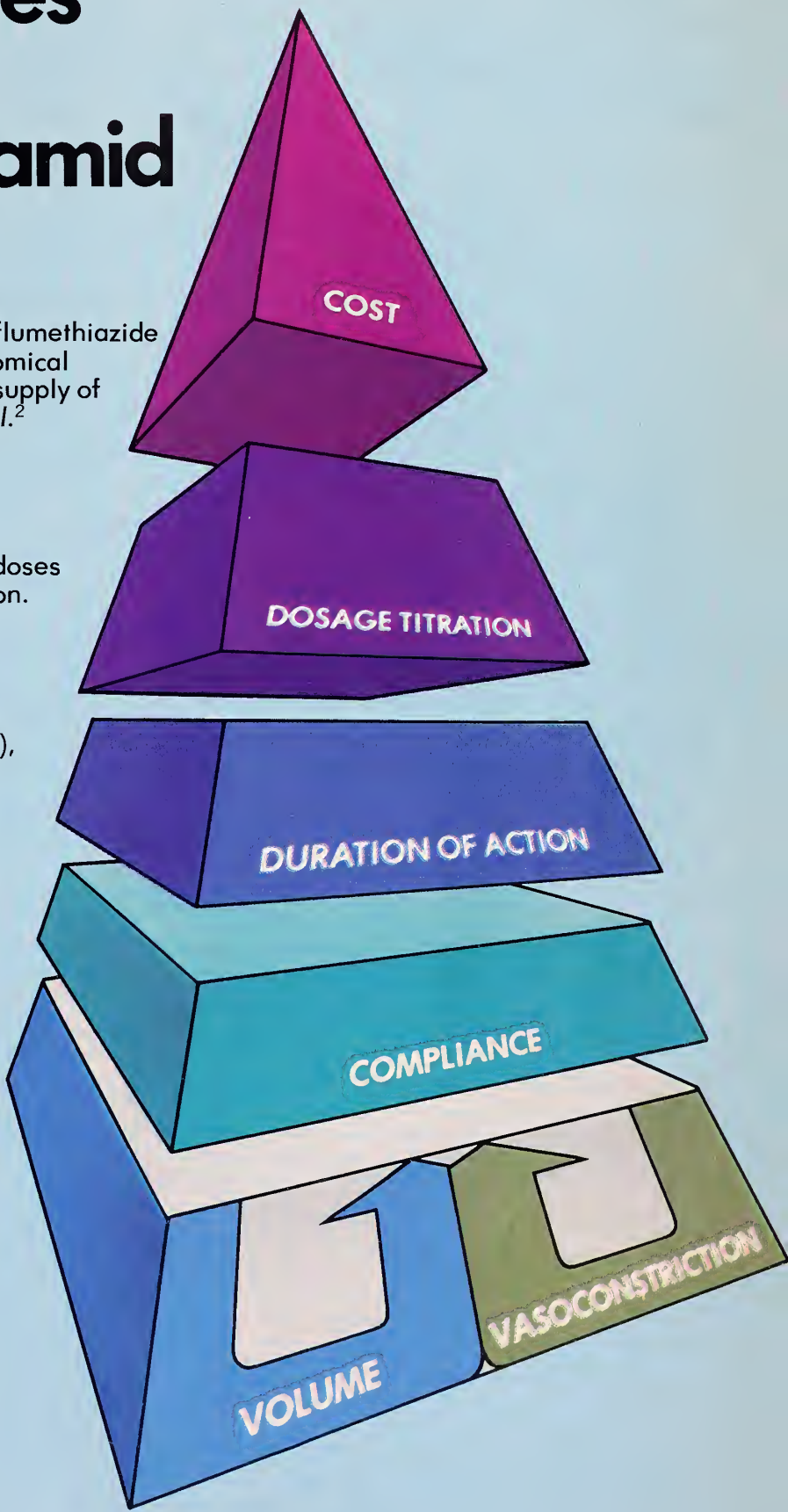


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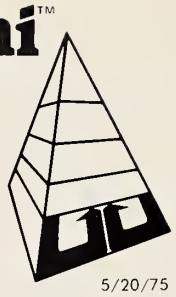
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Usage in pregnancy: Usage of thiazides in women of childbearing age requires that the potential benefits of the drug be weighed against its possible hazards to the fetus. These hazards include fetal or neonatal jaundice, thrombocytopenia, and possibly other adverse reactions which have occurred in the adult.

Nursing mothers: Thiazides cross the placental barrier and appear in cord blood and breast milk.

PRECAUTIONS: Periodic determination of serum electrolytes to detect possible electrolyte imbalance should be performed at appropriate intervals.

All patients receiving thiazide therapy should be observed for clinical signs of fluid or electrolyte imbalance; namely, hyponatremia, hypochloremic alkalosis, and hypokalemia. Serum and urine electrolyte determinations are particularly important when the patient is vomiting excessively or receiving parenteral fluids. Medication such as digitalis may also influence serum electrolytes. Warning signs, irrespective of cause, are: Dryness of mouth, thirst, weakness, lethargy, drowsiness, restlessness, muscle pains or cramps, muscular fatigue, hypotension, oliguria, tachycardia, and gastrointestinal disturbances such as nausea and vomiting.

Hypokalemia may develop with thiazides as with any other potent diuretic, especially with brisk diuresis, when severe cirrhosis is present, or during concomitant use of corticosteroids or ACTH.

Interference with adequate oral electrolyte intake will also contribute to hypokalemia. Digitalis therapy may exaggerate metabolic effects of hypokalemia especially with reference to myocardial activity.

Any chloride deficit is generally mild and usually does not require specific treatment except under extraordinary circumstances (as in liver disease or renal disease). Dilutional hyponatremia may occur in edematous patients in hot weather; appropriate therapy is water restriction, rather than administration of salt except in rare instances when the hyponatremia is life threatening. In actual salt depletion, appropriate replacement is the therapy of choice.

Hyperuricemia may occur or frank gout may be precipitated in certain patients receiving thiazide therapy.

Insulin requirements in diabetic patients may be increased, decreased or unchanged. Latent diabetes mellitus may become manifested during thiazide administration.

Thiazide drugs may increase the responsiveness to tubocurarine.

The antihypertensive effects of the drug may be enhanced in the postsympathectomy patient.

Thiazides may decrease arterial responsiveness to norepinephrine. This diminution is not sufficient to preclude effectiveness of the pressor agent for therapeutic use.

If progressive renal impairment becomes evident, as indicated by a rising nonprotein nitrogen or blood urea nitrogen, a careful reappraisal of therapy is necessary with consideration given to withholding or discontinuing diuretic therapy.

Thiazides may decrease serum PBI levels without signs of thyroid disturbance.

ADVERSE REACTIONS:

A. Gastrointestinal system reactions: Anorexia, gastric irritation, nausea, vomiting, cramping, diarrhea, constipation, jaundice (intrahepatic cholestatic jaundice), pancreatitis.

B. Central nervous system reactions: Dizziness, vertigo, paresthesias, headache, xanthopsia.

C. Hematologic reactions: Leukopenia, agranulocytosis, thrombocytopenia, aplastic anemia.

D. Dermatologic-Hypersensitivity reactions: Purpura, photosensitivity, rash, urticaria, necrotizing angiitis (vasculitis) (cutaneous vasculitis).

E. Cardiovascular reaction: Orthostatic hypotension may occur and may be aggravated by alcohol, barbiturates, or narcotics.

F. Other: Hyperglycemia, glycosuria, hyperuricemia, muscle spasm, weakness, restlessness.

Whenever adverse reactions are moderate or severe, thiazide dosage should be reduced or therapy withdrawn.

USUAL DOSE: The average adult diuretic dose is 25 to 200 mg. per day. The average adult antihypertensive dose is 50 to 100 mg. per day. Therapy should be individualized according to patient response. This therapy should be titrated to gain maximal therapeutic response as well as the minimal dose possible to maintain that therapeutic response.

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Use in pregnancy: Thiazides cross the placenta and can cause fetal or neonatal hyperbilirubinemia, thrombocytopenia, altered carbohydrate metabolism and possibly electrolyte disturbances. Fatal reactions may occur with reserpine during electroshock therapy; discontinue Salutensin 2 weeks before such therapy. Increased respiratory secretions, nasal congestion, cyanosis and anorexia may occur in infants born to reserpine-treated mothers.

PRECAUTIONS: Azotemia, hypochloremia, hyponatremia, hypochloremic alkalosis and hypokalemia (especially with hepatic cirrhosis and corticosteroid therapy) may occur, particularly with pre-existing vomiting and diarrhea. Potassium loss may cause digitalis intoxication. *Potassium loss responds to potassium-rich foods, potassium chloride or, if necessary, discontinuation of therapy.* Serum ammonia elevation may precipitate coma in precomatose hepatic cirrhotics. Discontinue therapy 2 weeks before surgery or if myocardial irritability, progressive azotemia or severe depression occur. Exercise caution in patients with chronic uremia, angina pectoris, coronary thrombosis or extensive cerebral vascular disease or bronchial asthma and in those with a history of peptic ulceration or bronchial asthma; in postsympathectomy patients; in patients on quinidine; and in patients with gallstones, in whom biliary colic may occur. Patients who have diabetes mellitus or who are suspected of being prediabetic should be kept under close observation if treated with this agent.

ADVERSE REACTIONS: Hydroflumethiazide: Skin-rashes (including exfoliative dermatitis), skin photosensitivity, urticaria, necrotizing angiitis, xanthopsia, granulocytopenia, aplastic anemia, orthostatic hypotension (potentiated with alcohol, barbiturates or narcotics), allergic glomerulonephritis, acute pancreatitis, liver involvement (intrahepatic cholestatic jaundice), purpura plus or minus thrombocytopenia, hyperuricemia, hyperglycemia, glycosuria, malaise, weakness, dizziness, fatigue, paresthesias, muscle cramps, skin rash, epigastric distress, vomiting, diarrhea and constipation. **Reserpine:** Depression, peptic ulceration, diarrhea, Parkinsonism, nasal stuffiness, dryness of the mouth, weight gain, impotence or decreased libido, conjunctival injection, dull sensorium, deafness, glaucoma, uveitis, optic atrophy, and, with overdosage, agitation, insomnia and nightmares.

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The cytogenetic characteristics and etiology of this disease have only recently been understood.

Diagnostic Value of Chromosome Studies in Leukemia

DAVE WELTER, Ph.D., *Augusta**

CHROMOSOME ABERRATIONS are frequent in myeloproliferative disorders, hematopoietic neoplasias, and solid tumors. Chronic granulocytic leukemia is the most significant of these disorders from a cytogenetic standpoint because of the presence of the Philadelphia (Ph) chromosome in 90% of the cases. In 1960, Nowell and Hungerford[1] discovered that the patient with chronic myelogenous leukemia (CML) usually presented with the Ph chromosome, an abnormally small chromosome 22, in bone marrow preparations. Since this initial correlation of a chromosome abnormality with neoplasia, a large amount of data has been collected on leukemias, other myeloproliferative disorders, and solid tumors. Investigators have had little success, however, in correlating the etiology of specific disorders with any non-random chromosomal error.

The new techniques of quinacrine fluorescence and Giemsa banding have permitted a reexamination of the question of non-random chromosomal abnormalities with much more precise methods than have been available previously. The findings have provided significant evidence about the role of genetic change in neoplasia, and they have also proved to be of some practical clinical value. The number of circumstances in which chromosome studies can be useful to the practicing physician in the diagnosis and prognosis of neoplasia still remains limited. It is the purpose of this paper to indicate the present status of this field and to suggest where chromosomal studies would be useful in diagnosis of neoplasia. Chromosomal bone marrow findings from the author's laboratory from 1975 to 1978 are presented and demonstrate the usefulness of chromosome studies in leukemias and other myeloproliferative disorders.

* Dr. Welter is an Associate Professor at the Medical College of Georgia. His address is Department of Anatomy, Medical College of Georgia, Augusta, GA 30902.

LEUKEMIA

Chronic Leukemia

CML is the only human malignancy in which a characteristic and typical change, translocation of part of the No. 22 chromosome to part of the No. 9 chromosome, has been reported in the majority of cases. The Ph chromosome is present in the neoplastic cells in 80-90% of typical cases of CML which, along with the observation of low leukocyte alkaline phosphatase, is strong confirmation of the clinical diagnosis. The presence of the Ph chromosome is usually associated with a good response to standard chemotherapy, whereas survival is significantly shorter in the absence of this chromosome. Apparently the shorter survival is related both to poor response to therapy and to the fact that the blastic phase may develop rather quickly. When patients with CML enter the blast transformation phase, additional chromosomal abnormalities are frequently superimposed on the Ph positive cell line. The involvement of chromosomes No. 7, No. 8, No. 10,

"The Philadelphia chromosome is usually associated with a good response to chemotherapy."

GLOSSARY

Karyotype: the number and structure of chromosomes in a cell nucleus; the karyotype is usually depicted as a photomicrograph of chromosomal material taken during metaphase with the individual chromosomes assorted according to pairs; karyotype abnormalities may be either of chromosome number or structure. The number of chromosomes in a normal individual is 46, of which 44 are the 22 pairs of autosomes, and the other two are sex chromosomes. Each of the 22 pairs of autosomes and the two sex chromosomes can be distinguished on the basis of size, location of the centromere (which divides the chromosome into arms of equal or unequal length), and the unique banding pattern as described below. The relative length of the arms and the position of the centromere are used as further criteria to divide human chromosomes into seven groups (A-G).

Aneuploid disease: a disorder in which there is an increase or decrease in the normal diploid number (46) of chromosomes.

Hypodiploidy: a genetic aberration in which there is a loss of one or more chromosomes.

Hyperdiploidy: a genetic aberration in which the number of chromosomes is in excess of the normal diploid number.

Banding techniques: methods of identifying characteristic patterns or "bands" on the arms of each individual chromosome; presently, a fluorescent dye such as quinacrine hydrochloride or an azurophilic stain (Giemsa) is most commonly used to produce "banding" patterns.

Quinacrine fluorescent method: a technique in which chromosomes are exposed to a fluorescent quinacrine derivative after which the chromosome fluoresces; the degree of fluorescence varies from one part of the chromosome to another; the resulting fluorescent pattern of "bands" on the chromosomal arms is characteristic for each chromosome.

Giemsa method: chromosomes stained with Giemsa stain at pH 9.0 show deeply stained bands that are characteristic for each chromosome.

Non-random error: a chromosomal aberration arising spontaneously in a single cell or population of cells in a previously normal genetic individual; chromosomal abnormalities are frequently found in patients with acute leukemia as described in this paper. It is possible that such an error may give a proliferative advantage to the abnormal clone of cell or cells.

Philadelphia chromosome: approximately 85% of patients with chronic granulocytic leukemia have been found to have an abnormal karyotype. Such patients were originally thought to have an "extra," small, single chromosome found in dividing bone marrow cells. This chromosome was designated as the Philadelphia (Ph) chromosome. Banding techniques have now shown that the Ph chromosome is really a fragment of human chromosome 22; the remainder of chromosome 22 has been translocated or adjoined to the long arm of human chromosome 9. The absence of the Ph chromosome in chronic granulocytic leukemia has been shown to be a poor prognostic sign. The Ph chromosome is found only in precursor cells of granulocytes, erythrocytes, and platelets; it is not found in other somatic cells.

No. 19, No. 21, and Y occurs more frequently than with other chromosomes. However, the most common change in the blastic phase is the development of extra Ph chromosomes. The loss of the Y chromosome in marrow cells occurs rather frequently after the age of 70, with about 5-10% of male CML patients presenting with this chromosomal error. These patients have a somewhat better prognosis and develop a more benign clinical course than males with the Y chromosome.[2]

The chromosomal picture in chronic lymphocytic leukemia (CLL) has not been established with certainty due to the difficulty of ascertaining the origin of the metaphases examined. In this disease, the mitotic index is very low, and it is almost impossible to determine if the metaphase in question is of normal or neoplastic origin. Sandberg[2] states that CLL is probably not an aneuploid disease.

Acute Leukemia

In acute leukemia, chromosomal errors are found in about 50% of the cases. In acute myeloblastic leukemia (AML), hypodiploidy and hyperdiploidy

"In acute leukemia chromosomal errors are found in 50% of the cases."

are common findings. The chromosome numbers may range from 40 to 60. In AML, which exhibits a chromosomal error, there are two distinct groups. One exhibits a minor karyotype abnormality which is usually a translocation between chromosome No. 8 and chromosome No. 21. The patients with this minor error respond well to chemotherapy and have a good prognosis. In the second group of patients with AML, there are major karyotypic abnormalities in addition to the 8/21 translocation. For example, abnormalities of chromosome numbers 7, 8, 10, and 21 are also found. These patients respond poorly to therapy and have a poor prognosis. In both groups, patient response to therapy can be correlated with the percent of normal cells in the marrow. The more normal cells present, the greater the response to therapy and the longer the survival.[2]

In acute lymphoblastic leukemia (ALL), as in AML, about 50% of these patients have chromosomal abnormalities. No specific chromosomal changes have been established, but there are several characteristics which index the presence of leukemia cells. Hyperdiploidy is common, but hypodiploidy is rarely observed. Fuzzy, ill-defined chromosomes which are difficult to band and identify are a characteristic of ALL metaphases.

Disorders which comprise the so-called "myeloproliferative syndrome" include such entities as polycythemia vera, myelofibrosis with myeloid metaplasia, and chronic refractory anemia. Rather than discuss the chromosomal finding for each of the remaining hematologic disorders, the clinical condition and its associated chromosomal findings are listed in Table 1, along with those disorders already discussed. This table lists only those hematologic disorders associated with chromosomal disorders.

TABLE 1 — Chromosome Abnormalities Associated With Neoplasia

Condition	Chromosome Abnormality Most Commonly Found
Chronic myelogenous leukemia (CML)	1) Ph chromosome present in 90% of cases.[9, 10] In blast crisis extra Ph chromosome(s) present.
	2) Absence of the Y chromosome in 5% of the cases.
Acute myelogenous leukemia (AML)	1) 50% of these cases have chromosomal abnormality. Minor karyotype abnormality with an 8/21 translocation.[2]
	2) Major karyotype abnormality with an 8/21 translocation, loss of an X chromosome and abnormalities of chromosome number 7, 8, 10, and 21.
Chronic lymphoblastic leukemia (CLL)	Not an aneuploid disease.[2]
Acute lymphocytic leukemia (ALL)	50% of these patients have chromosome abnormalities. No specific chromosome, but hyperdiploidy and fuzzy, ill-defined chromosomes are associated with the disease.[2]
Polycythemia vera	Loss of long arm of chromosome No. 20 in about 20% of cases.[9]
Burkitt's lymphoma and multiple myeloma	Abnormally long chromosome 14[8] may be result of reciprocal translocation with long arm of 8.[13]
Myelofibrosis and myeloid metaplasia	C group (chromosome 6 to 12 and the X) involvement may occur with more than random frequency.[3]
Pre-leukemia	Same types and frequency as found in acute myelogenous leukemia.[6]
Chronic refractory anemia	Number 5 chromosome long arm shows deletion.[11]
Retinoblastoma	Interstitial deletion long arm chromosome 13.[12]
Non-Hodgkin's lymphoma	8-14 translocation.[7]

TABLE 2 — Bone Marrow Chromosomal Findings Associated With Blood Dyscrasias, 1975-1978, Augusta, Georgia

Original Diagnosis	Total Patients	Chromosomal Findings
Chronic myelogenous leukemia (CML)	21	Ph^+ in 18 of 21
Acute myelogenous leukemia (AML)	1	C/G (presumably 8/21) translocation
Polycythemia vera	8	No abnormalities in any of the 8
Megakaryocytic myelosis	1	Deletion of long arm of No. 10 chromosome
Preleukemia	2	Normal karyotype
	1	C/? translocation, extra chromosomal material on the long arm of one C-group chromosome
Multiple Myeloma (Terminating in Acute Myelogenous leukemia)[6]	1	Hypodiploid and Ph positive
Total	35	22 of 35 with chromosomal abnormalities

PRELEUKEMIA

Syndromes preceding overt or frank leukemia are referred to as preleukemic states or clinical preleukemia. Nowell[3] pointed out that a number of disease states (preleukemic) carry a significant risk of developing into frank leukemia. He divided these disease states into three groups: (1) a variety of cytopenias which ultimately progress to nonlymphocytic acute leukemia, (2) myeloproliferative disorders, such as polycythemia vera, myelofibrosis, undifferentiated myeloproliferative disorders, and primary thrombocytosis, all of which may eventually progress to leukemia, and (3) certain congenital and childhood disorders, such as Bloom's syndrome, Fanconi's anemia, ataxia telangectasia, and cases of unexplained marrow hypoplasia which carry an increased risk of leukemia. The manner in which leukemia begins is unknown. It has been well documented that, in some instances, overt leukemia is preceded by hematologic abnormalities without definite leukemic features. Most probably these events begin as a clone of aneuploid cells. A clone of chromosomally abnormal cells in the bone marrow of individuals with clinical features of preleukemia is a grave prognostic sign. This usually indicates that leukemia is already present and will soon become clinically apparent. Pierre[4] found that cytogenetic abnormalities were present in the preleukemic phase of acute leukemia with approximately the same frequency and type in which they were seen in acute leukemia. Genetic changes, often visable cytogenetic alterations, may occur as a result of the instability of these clones. When these changes occur, acute leukemia often ensues.

"A clone of chromosomally abnormal cells in the bone marrow usually indicates that leukemia will soon become clinically apparent."

SOLID TUMORS

Little information of practical clinical value has thus far been obtained on chromosome abnormalities in human solid tumors. Almost all human tumors of malignant nature have been shown to have chromosomal change, but these changes are of an extremely variable nature, without any consistent karyotypic abnormality characterizing any specific tumor. The technical difficulty of obtaining adequate preparations for study have made cytogenetic diagnosis impractical with few exceptions. Mark et al.[5] have demonstrated that most meningiomas are missing a G group chromosome. In cervical carcinoma, cerebral gliomas, and primary testicular tumors, significant gains or losses within certain chromosomal groups have been noted.

DISCUSSION

In the investigation of 35 patients in this laboratory (Table 2), it was demonstrated that 22 individuals suspected of blood dyscrasias were found to have chromosomal errors. The absence of karyotypic abnormality in three patients suspected of having CML was the only unexpected finding in this series. These three patients were diagnosed as possible CML cases prior to examination of the bone marrow for neoplastic changes. The most interesting case was the one with megakaryocytic myelosis, which demonstrated a long arm deletion of chromosome number 10. This patient was successfully treated, and the abnormal bone marrow clone was completely eliminated. This patient is now 5 years post-treatment and has no hematologic abnormalities.

Blastic crisis was confirmed, with the presence of additional chromosomal errors or additional Ph chromosomes, in several of the CML patients. This cytogenetic diagnosis consistent with blastic crisis enabled the physician to better manage these patients.

In the one case of multiple myeloma terminating

in AML,[6] the chromosomal studies enabled us to confirm the transition from one disease state to another.

To date, bone marrow cytogenetic evaluations are difficult to obtain, since the technique is different from peripheral blood and most laboratories do not do them. Another problem involved in marrow evaluation is that for best results the marrow aspirate should be processed immediately, which eliminates the transporting of marrow from the donor to the available laboratory. The patient sample should be obtained in close proximity to the cytogenetics laboratory for best results. The availability of cytogenetic laboratories that use all of the special techniques available presents an additional problem, since there is only one such laboratory in the state at this time.

CONCLUSION

Banding techniques have enabled cytogeneticists to accumulate evidence that various non-random chromosomal patterns are present in hematopoietic neoplasias and some solid tumors. Since response to standard therapy in the patient with CML with the presence of the Ph chromosome versus the CML patient without the Ph chromosome is different, a chromosomal evaluation gives the physician another dimension in the management of this disease. To date, no demonstrable non-random chromosomal abnormality has been shown in CLL. In cases where diagnosis of acute leukemia is in doubt, chromosomal errors in marrow are strong evidence of neoplasia. The absence of chromosomal error does not rule out the diagnosis, however, since only 50% of acute leukemic marrow show chromosomal changes. Of those with chromosomal error, it is important to know whether there is a minor or major karyotypic alteration, since the patient with a minor error will respond to therapy and have a good prognosis, whereas one with the major error has a very poor prognosis. Fuzzy, ill-defined chromosomes are presumptive evidence of ALL in about 50% of the patients suspected of having this disease. In preleukemia, a clone of chromosomally abnormal cells frequently indicates that frank leukemia will soon become manifest. Because of the difficulty of identifying the origin of the cells analyzed and the low mitotic index, the cytogenetic picture of most solid tumors is difficult to evaluate, although most tumors show a variety of random chromosomal alterations.

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Paying Sam Back

(Editor's Note: This excerpt is from a profile of Bernard Meltzer written by J. Stevenson and published in the August 1978 issue of The New Yorker *entitled, "Paying Sam Back.")*

(Meltzer said,) "The second year (at City College of New York), I didn't have the money to buy books to start the year. I couldn't borrow the money anywhere. Finally, I decided to ask an old attorney who lived in our neighborhood. His name was Sam, and by American standards he would be considered a failure. . . . Anyway, I went to him. We talked, and we figured out I needed ninety dollars. I said, 'Sam, I don't know when I'll pay you back.' His reply has been with me my whole life. He said, 'This is going to be the hardest debt in the world to pay back. I want no interest. You're not going to pay me back in money. But when anybody needs help, you're going to help him, and you're going to say to yourself, "I'm paying Sam back."' " Meltzer was suddenly unable to continue. Then, after a few moments, he said, "When I help somebody now — and almost any kid can hit me for money for school — I get that same pledge from them."

The author's experience with 100 patients with tear duct obstruction supports a conservative approach in the management of this condition.

Tear Duct Obstruction in Babies

ZANE F. POLLARD, M.D., *Atlanta**

Introduction

As a pediatric ophthalmologist, I am frequently asked by pediatricians what to do about tear duct obstructions in babies in their first year of life. There is a wide variance of opinions as to when probing should be performed. Some physicians feel no child should be referred until the age of one. Yet there are some ophthalmologists who believe all patients should be referred for treatment as soon as the problem arises. Somewhere in between these two extremes lies a more accurate assessment of the problem. There is a paucity of papers in the literature dealing with this problem. In 1935, Riser[1] reported 21 of 32 patients or 65% with tear duct obstruction early in life responded to massage; 11 had to be probed after they failed to open with conservative measures.

This condition has been estimated to occur in 6% of full term infants.

This paper will present a study of 100 babies who presented to the author in the first 6 months of life with tear duct obstruction. None had any secondary complications so they were followed conservatively in the first 6 months of life to see if the tear duct obstruction would open by massaging the tear sac three times a day. After 6 months of age, those babies who still had an obstruction were treated by probing of the naso-lacrimal duct. The purpose of the study was to see what percentage could be successfully treated conservatively during the first 6 months of life. Also to be discussed will be the treatment of babies who present with tear duct obstruction after 6 months of age.

Materials and Methods

There are two complications of obstruction of the naso-lacrimal duct which require early probing. One is an infection of the lacrimal sac called dacryocystitis. The second is a mucocele of the lacrimal sac. A mucocele presents as a bluish mass in the area of the lacrimal sac. It is actually a distension of the lacrimal sac with mucoid-like fluid secondary to a tear duct obstruction. These usually were referred with a diagnosis of hemangioma because of the blue coloration. Babies who presented with these two complications were probed regardless of their age and were not included with the 100 patients followed conservatively. This is because we did not want to risk the chance of recurrent infections.

Most of the babies with acute dacryocystitis presented with a swollen lacrimal sac, fever, and a purulent discharge which was more copious when pressure was applied to the lacrimal sac. Ten patients presented with acute dacryocystitis in the first month of life. Four were bilateral. All were treated for 5-7 days with topical antibiotics in the form of eyedrops. This was followed by probing done in the office. Two children aged 2½ and 3½ presented with acute dacryocystitis and were probed in the hospital under general anesthesia. Five babies in the first 3 weeks of life presented with mucocele and were probed in the office.

In performing a probing, a thin wire is passed into the puncta, through the canaliculus, into the tear sac, and down the naso-lacrimal duct. It continues past the obstruction at the end of the naso-lacrimal duct and then into the nose. Babies less than 1 month of age were probed in the office with a nurse assisting.

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After 1 month of age, a baby is usually too strong to be probed without general anesthesia.

All of the babies who presented with tear duct obstruction in the first 6 months of life (without acute dacryocystitis or mucocele) were treated conservatively by massaging the tear sac three times a day. It was hoped that a forceful flow of tears down the tear duct would open the obstruction. If the patient still showed signs of tear duct obstruction after 6 months, then a probing was performed under general anesthesia. Babies who presented for the first time to the ophthalmologist after 6 months of age were all treated with probing without massaging.

Results

In the group of 100 patients who were followed conservatively in the first 6 months of life by massaging three times a day, 41% responded successfully. Fifty-nine had a probing of their naso-lacrimal duct performed shortly after 6 months of age, 54 were successfully probed the first time, four were successfully probed a second time, and one patient who had two unsuccessful probings had to be treated with a dacryocystorhinostomy. In addition, there were 10 patients who presented in the first month of life with acute dacryocystitis and five who presented in the first month of life with a mucocele. All were successfully probed in the office shortly after their condition was diagnosed.

Forty-one percent of the patients under 6 months of age responded successfully to conservative treatment.

Thirty-five patients presented with tear duct obstruction after 6 months of age. In this group, 25 were successfully probed the first time, five were successfully probed a second time, and five had a dacryocystorhinostomy, as probing was unsuccessful (Table 1). Probing of the naso-lacrimal duct was most successful when performed on a baby under 1 year of age. Of the total number (150) of patients, five of the six who required a dacryocystorhinostomy had presented to the ophthalmologist with his tear duct obstruction after the age of one. While there were five unsuccessful probings in children presenting after the age of one, it is interesting to note that there were also five successful probings in children who presented after this age. Four of these children were between the ages of 3 and 5, with tearing since birth, who were cured with one probing of their naso-lacrimal duct.

Comments

Newborn babies do secrete tears in the first 24 hours of life.[2] Tears enter the outflow system through the puncta. The puncta is a dot-like opening located at the edge of the medial third of the upper and lower eyelids. The lower puncta carries 80% of the tears, and the upper one carries 20%. From there, the puncta leads to the vertical segments of the lacrimal canaliculus which is 1-2 mm. in length. Then the canaliculus runs horizontally toward the nose for 6-8 mm. to enter the lacrimal sac (10-15 mm. in vertical length). At the lower end of the lacrimal sac, the naso-lacrimal duct begins and continues downward toward the nasal cavity just under the inferior turbinate.

In neonates with a bluish mass in the area of the lacrimal sac, a diagnosis of mucocele should be considered.

Most tearing is due to a failure of canalization of the naso-lacrimal duct. This was first pointed out by Zentmayer[3] in 1908 and was later also found to be true by Nordlow[4] in 1953. The site of this location is usually at the entrance of the duct into the nose. Failure of canalization results in atresia of the duct. The obstruction is rarely due to an imperforate puncta or canaliculus. The obstruction has been estimated to occur in 6% of full term infants.[5, 6] Ten

TABLE 1 — Treatment of Children with Naso-lacrimal Duct Obstruction 1976-1978, Atlanta, Georgia

Age	Number of Patients	Problem	Treatment and Results
Under 1 month	15	10 Dacryocystitis 5 Mucocele	10 successfully probed in office 5 successfully probed in office
1-6 months	100	Tear duct obstruction	41 opened with massage 54 probed successfully first time 4 probed successfully second time 1 unsuccessful with 2 probings, successful with dacryocystorhinostomy.
Over 6 months	35	Tear duct obstruction	25 probed successfully first time 5 probed successfully second time 5 unsuccessfully probed third time, treated successfully with dacryocystorhinostomy.

percent of all cases of acute dacryocystitis occur in children under 1 year of age.[7]

Upon taking a careful history from the family, we find that tearing began either at birth or shortly thereafter. We must consider tear duct obstruction after first ruling out the usual causes of excessive neonatal tearing: silver nitrate, staphylococcus, gonococcus, and Chlamydia. Occasionally, the family reports that tearing began on the second or third month of life; usually, however, it presents at birth. If a tear duct obstruction persists, a secondary conjunctivitis may occur.

Summary

We have shown that babies under 1 month of age with tear duct obstruction leading to acute dacryocystitis or mucocele of the lacrimal sac can be successfully probed in an office. In neonates with a bluish mass in the area of the lacrimal sac, a diagnosis of mucocele should be considered. In babies who present with just tearing due to a naso-lacrimal duct obstruction without dacryocystitis or mucocele, 41% spontaneously opened with conservative management up to 6 months of age. After 6 months of age, all patients were probed under general anesthestic. Five of the six cases which eventually had to have a dacryocystorhinostomy had their first probing after the age of one.

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References: 1. Citations available on request—Medical Research Department, MERRELL RESEARCH CENTER, MERRELL-NATIONAL LABORATORIES, Cincinnati, Ohio 45215. 2. Hoekenga, M.T., O'Dillon, R.H., and Leyland, H.M.: A Comprehensive Review of Diethylpropion Hydrochloride. International Symposium on Central Mechanisms of Anorectic Drugs, Florence, Italy, Jan. 20-21, 1977.

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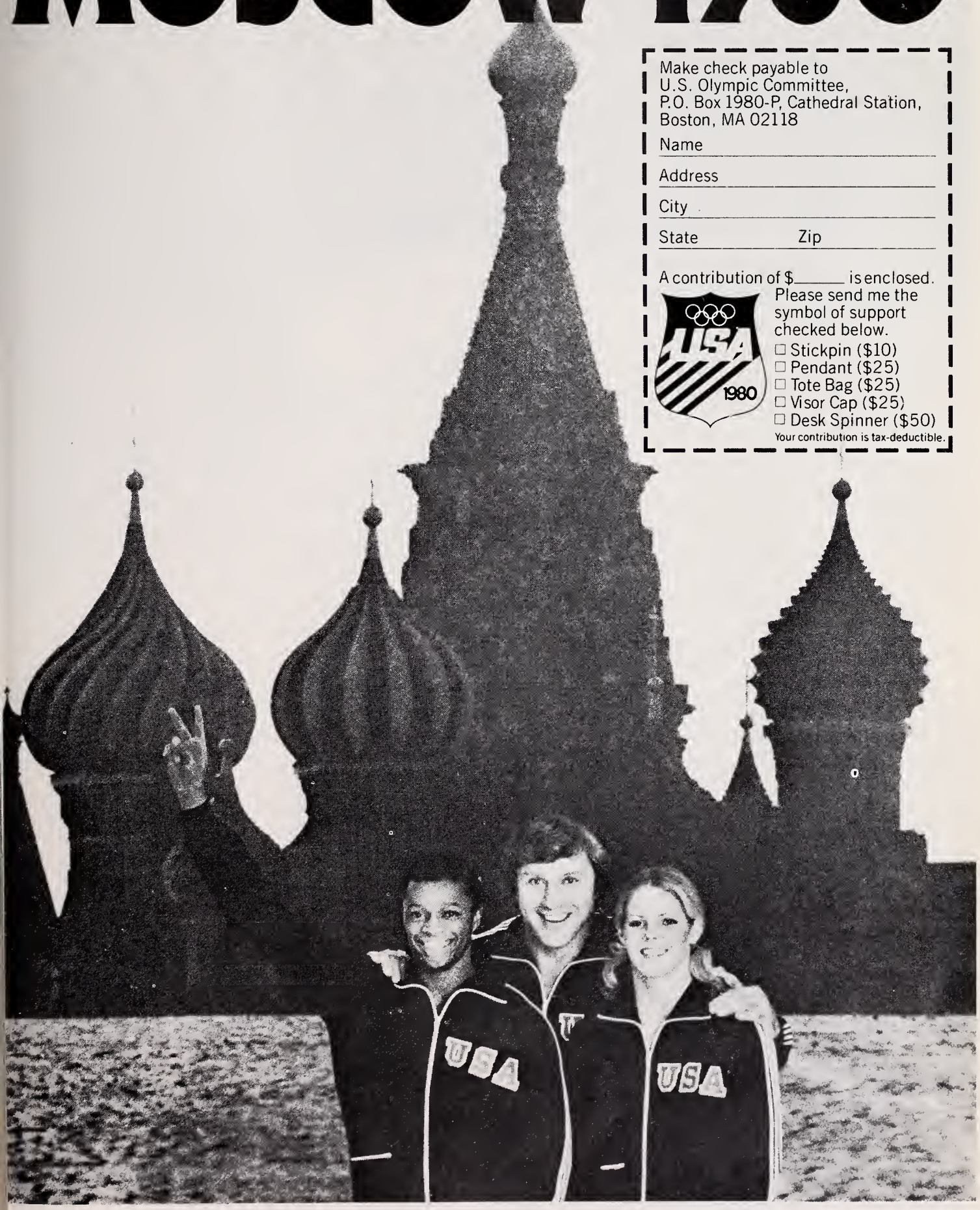
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The author points up the necessity of considering **Hemophilus influenzae** *as a causative agent of meningitis.*

Neonatal *Hemophilus influenzae* Meningitis — A Case Report

TOMMY JOINER, B.S., and KENNETH C. HENDERSON, M.D., *Macon

Introduction

MENINGITIS HAS ITS ONSET more frequently in the first month of life than in any subsequent 30-day period of life.[1] Its morbidity and mortality in the neonate remain a formidable challenge in spite of apparently appropriate parenteral antibiotic therapy. Although the coliform organisms, especially *Escherichia coli (E. coli),* are the main causative agents of bacterial meningitis in the newborn, Group B Streptococcus recently has become an important and, in some institutions the most common, cause of bacterial meningitis. The purpose of this report is to draw attention to *Hemophilus influenzae (H. influenzae),* which is not generally considered in the group of causative agents of meningitis. An awareness of this organism as a possible etiologic agent is important because of its critical requirements for in vitro growth and its specific antibiotic sensitivities.

Case Report

On Oct. 9, 1978, a 21-year-old gravida 2, para 1, Caucasian woman gave birth to a 2,155 gram female infant. Gestational age was estimated to be 34-36 weeks. On admission, the mother gave an indefinite history of leaking membranes. She had trichomonas vaginitis and scabies and was afebrile.

The infant was delivered vaginally in a sterile, spontaneous manner without the use of instruments. The Apgar was 9 both at 1 and 5 minutes. The infant ate and did well initially. On the third day, she experienced a non-hemolytic jaundice with a total bilirubin level of 13.4 mg%. A blood specimen was cultured, and she was treated with phototherapy to reduce the bilirubin level. The following day, she apparently had an episode of apnea and cyanosis. Her temperature was 100.2 F. Repeat blood and urine specimens were obtained. Later that day the infant became very irritable, and hypertonicity of both upper and lower extremities was observed. She was opisthotonic, held her thumbs in her fists, and displayed a high-pitched cry in response to movement. A lumbar puncture was done, and the infant was placed on ampicillin (100 mg per kilo per day) and gentamicin (7.5 mg per kilo per day) intravenously. Culture of the blood specimens revealed a heavy growth of *H. influenzae*. The cerebrospinal fluid (CSF) specimen revealed growth consistent with *H. influenzae;* this was later confirmed by the State Laboratory, Georgia Department of Human Resources in Atlanta, Georgia. Efforts to type the *H. influenzae* were unsuccessful at the State Laboratory and at the laboratory at the Center for Disease Control in Atlanta. This was due to the fact that this strain was a nontypable (nontype B) strain, in spite of optimal technique. The second CSF specimen obtained after 24 hours of antibiotic treatment revealed no growth. Gentamicin was discontinued after 5 days, and 200 mg per kilo per day of ampicillin was administered intravenously for an additional 5 days. The mother was discharged from the hospital 3 days after delivery. She was brought back to the clinic 1 week after delivery so that cervical and vaginal specimens could be obtained. Cultures of these specimens revealed no growth of *H. influenzae*.

Discussion

Although *H. influenzae* has previously been considered to be an uncommon cause of systemic disease in neonates, infections with *H. influenzae* are being reported with increasing frequency.[2-7] Table 1 shows past experience with *H. influenzae* infections. The medical literature between 1933 and 1973

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contains reports of only 17 cases of systemic *H. influenzae* infection occurring in infants under 4 weeks of age. Seven of those were due to type B, while in the remaining 10, the organism type was not described. Of the 17 cases of neonatal *H. influenzae* infection occurring between 1933-1973 in which the source of the infection was clearly identified, 12 were meningitis cases.

TABLE 1 — Spectrum of *Hemophilus influenzae* Infections in the Neonate — 1933-1978

Site of Infection	Number of Cases	Reference
Abscess	4	3, 5, 9, 12
Mastoiditis	1	7
Meningitis	14*	2, 6, 7, 13
Otitis media	1	8
Pneumonia	4	4, 9, 11
Septic arthritis	2	6
Septicemia	14	2, 4, 5, 9, 10, 12, 15
Source undetermined	1	
Total	41*	

* Includes present report.

During the 6-year period from 1973 to 1978, an additional 22 cases of neonatal *H. influenzae* infection were reported (not including our case), with only one of these being a case of meningitis.[2-7, 9-11] These recent reports represent a rate of 3.7 cases per year, or approximately a 9-fold increase in the incidence of neonatal *H. influenzae* infection when compared to the preceding 40-year period (0.43 cases per year). On the other hand, the two cases of neonatal *H. influenzae* meningitis reported during the last 6-year period (including our case, 0.33 cases per year), represents an incidence basically unchanged from the preceding 40-year period (total of 12 cases of *H. influenzae* meningitis or 0.3 cases per year). These figures are based, however, on published literature and are thus probably not a reflection of true incidence.

In recent years, there apparently has been an increase in the incidence of *H. influenzae* infections in children[14, 16] and adults.[17] However, there is no hard data to support this suggestion. With the increasing incidence of *H. influenzae* infections in teenagers,[18]

***"Gram-negative bacilli on a gram stain of CSF fluid can no longer be assumed to be* E. coli."**

it may be speculated that there will be an increasing number who will have *H. influenzae* in their birth canals. Recent reviews have shown that *H. influenzae* is one of the organisms which, when present in the maternal genital tract, can cause fulminant neonatal septicemia.[2, 11] Therefore, the increasing incidence of teenage pregnancy may be expected to lead to an increasing number of infections with *H. influenzae,* as has been evidenced since 1973. There are, however, no detailed prospective epidemiologic studies in which the frequency of colonization of the female genital tract with *H. influenzae* has been evaluated carefully.

With this evidence of increased neonatal *H. influenzae* meningitis, one must be especially careful with its diagnosis or the lack of same. Gram-negative bacilli on a gram stain of CSF fluid can no longer be assumed to be *E. coli*. *H. influenzae* must be considered as an etiologic agent of neonatal meningitis, and appropriate steps must be taken to isolate, grow, and determine the specific antibiotic sensitivities of the bacterial agent. In a neonate with meningitis in which the CSF gram stain shows the presence of gram-negative bacilli, antibiotic coverage for aerobic enteric organisms (for example, *E. coli* and *H. influenzae*) should be considered. It must be remembered that appropriate coverage for *H. influenzae* meningitis may include both ampicillin and chloramphenicol, since the annual incidence of ampicillin-resistant *H. influenzae* has increased to a mean annual rate of up to 16%.[19] Chloramphenicol should be cautiously administered to the newborn infant. It has been well documented that it is absolutely essential to monitor the blood levels of chloramphenicol.

". . . it is absolutely essential to monitor the blood levels of chloramphenicol."

The only case of neonatal *H. influenzae* meningitis in the last 5 years, besides the one presented here, resulted from direct extension of the infection from the mastoid. The mechanism for acquisition of the infection in our case is unknown: however, there is no reason to believe the mechanism of acquisition differs from that responsible for neonatal sepsis due to other organisms. Documentation of maternal postpartum bacteremia due to *H. influenzae* has been reported, as has the presence of this organism in the female genital tract.[2, 4] Whether mother and infant are simultaneously infected at birth by dissemination from the maternal genital tract or whether the infant was infected postpartum by the mother is most often unclear, since optimal specimens are not often taken from the maternal genital tract or nasopharynx at the time of birth.

The low incidence of *H. influenzae* infections in newborns has been attributed to transplacental transfer of bacterial antibodies against the organism.[20] In view of the postulate that neonatal infections due to *H. influenzae* occur in infants whose

mothers lack immunity,[21] maternal infection could be anticipated to occur and cause systemic infection in the mother as well. This has been found to be true, however, in only two of the 40 recorded cases of neonatal *H. influenzae* infection.[10, 15] Additionally, 30% of newborn infants evaluated in another study lacked *H. influenzae* type B bactericidal activity.[22, 23] Therefore, the incidence of neonatal *H. influenzae* infections has not paralleled the number of potentially susceptible individuals. Numerous papers by many authors now suggest, on the basis of both human and animal experiments, that antipolyribosephosphate capsular antibody is at least one of the determinants of protection from *H. influenzae* disease, whereas bactericidal antibody appears to be only of secondary importance.

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The Physician as a Writer

JOHN DAVIS CANTWELL, M.D., *Atlanta**

Introduction

SOMERSET MAUGHAM once said that the life of a physician is one of the best backgrounds for becoming a writer, for that profession takes one into the vast spectrum of human experience. I could not agree more, for my work has taken me into the locker room of the physical elite (as a team doctor for the Atlanta Braves) and into the lives of those who are less fortunate (as team physician for the Georgia Special Olympics). It has enabled me to serve for 2 years in the rough and tumble Atlanta Federal Penitentiary, to deliver babies in the Chicago ghettos, and to meet the two extremes of Atlanta society — from the company president to the welfare patient at Grady Memorial Hospital. I cherish each experience, for as Tennyson once wrote, "I am a part of all I have met."

It was said of the late Paul Dudley White that there was no way to measure his impact, for a master teacher influences his students, who in turn influence another generation of students, and so on and so on. A writer, like a teacher, has an even greater influence. A general practitioner from Alabama once introduced himself to me and stated that he was enjoying my book, *Modern Cardiology*. Up to that point, the book had been a very solitary undertaking — rough drafts on yellow legal pages, copy editing, galley proofs, finally the end product — and it suddenly dawned on me that there were people out there actually reading the book and using it in their medical practice.

It is important to know when to write and when not to! Voltaire had this to say: "Do you wish to make a book? Remember that it must be new and useful, or at least have great charm." He went on to say that "it is far better to be silent than merely to increase the quantity of bad books."

Experience Is Important

The successful physician-author must combine experience with writing and voracious reading. We need to acquire, as Adlai Stevenson noted, "a knowledge not gained by words but by touch, sight, sound, victories, failures, sleeplessness, devotion, love — the human experiences and emotions of this earth and of oneself and other men." I was sorry that my grandfather was not a writer, for I would like to have shared his many experiences in 50 years as a small-town physician.

Osler and Paracelsus had the same philosophy. The former said that "to study the phenomena of disease without books is to sail an uncharted sea; while to study books without patients is not to go to sea at all." Paracelsus stated that "my books are not written like those of other physicians, merely copying the ancient authorities. I have composed them on the basis of experience, which is the greatest master of everything." He went on to advise us to "look, observe, go back to the bedside; be suspicious of eloquence, ignore ceremony, lecture and write in the common language, proceed from reason, and move on the learning of experience."

The Joy of Writing

Even though writing is hard work, requiring a lot of self-discipline, it is nonetheless a joyful avocation. It satisfies the creative need and enables one to become a more effective teacher and lecturer. For some it is far more than that; it becomes an escape or even a means of preserving one's sanity, of staying alive. Consider the words of Solzhenitsyn while languishing in a Siberian prison camp:

> "So I went on writing. In winter, in the warming-up shack, in spring and summer on

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the scaffolding at the building site; in the interval between two barrel loads of mortar, I would put my bit of paper on the bricks and (without letting my neighbors see what I was doing) write down with a pencil stub the verses which had rushed into my head while I was slapping on the last hodful. I lived in a dream, sat in the mess hall over the ritual gruel sometimes not even noticing its taste, deaf to those around me — feeling my way about my verses and trimming them to fit like bricks in a wall. I was searched and counted and herded over the steppe — and all the time I saw the sets for my play, the color of the curtains, the placing of the furniture, the spotlights, every movement of the actors across the stage.''

My Writing — And My Addiction

To me, writing appears to be a God-given talent, perhaps inherited from my mother's side of the family. Her uncle, a former dean of the University of Illinois Medical School, was a prolific author and historian. My interest has undoubtedly been kindled by an addiction to books. My wife has suspected it for several years, and I became convinced myself after a trip to Germany. I am hooked on bookstores — flat out addicted! Why else would I be drawn to them, like a diviner's rod is to an underground spring, in a country whose language I can neither read nor speak. I even get withdrawal symptoms (nervousness, irritability, muscle twitches) when I have not frequented a bookstore in several days. I smuggle hardback books into the house like a drunk does bottles, concealing them in briefcases, wrapping them in newspapers or tucking them inside my sport coat. If my wife ever found out how much I spend on books she would probably render me bankrupt in a retaliatory shopping spree at Saks. But how else would I have come to meet the likes of Hardy's Eustacia Vye or Salinger's Holden Caulfield, to learn from Tom Sullivan about blindness, to see the magnificent determination of Gandhi through the eyes of Collins and LaPierre; to share Douglas-Hamilton's adventures ''among the elephants.''

''I am hooked on bookstores. . . . I even get withdrawal symptoms (nervousness, irritability, muscle twitches) when I have not frequented [one] in several days.''

I sometimes think that I write books only to give me the opportunity to dedicate them to those important to me. The first edition of *Exercise and Coronary Heart Disease* was dedicated to my parents, who ''taught physical fitness and athletic participation as a way of life.'' I dedicated the second edition to my children:

> ''To Bradley — and those who have touched my life and heart through his affliction.*
> To Kelly — who proves that little girls really are made of sugar 'n spice.
> To Ryan — who carries the family banner into the next century. Steel true, blade straight — and slide head-first on close plays at second base.''

Modern Cardiology was dedicated to my wife, to whom I quoted 1 Corinthians 13:4-8 in appreciation of her love and support.

My writing career has been aided by a good family life, an aversion to television, an inner desire to always utilize free time, and a career that blends a variety of experiences. In writing short stories I try to begin with a catchy title (''Docs Who Were Jocks,'' ''On Olympic Games, Beggars, and a Boy Named Brad''), cite a personal experience that involves emotion, and conclude with a tidy ending.

Like most writers, I pretend to be oblivious to the critic's comments, but in fact read their every word and am far more sensitive than I like to admit. When faced with negative comments I used to fall back on the words of Theodore Roosevelt, who said in effect that ''its not the critic who counts, but the man in the arena.'' A former president used this as his post-Watergate ''swan song,'' however, rendering it impotent for my needs. Perhaps I should try Voltaire, who said:

> ''A hundred authors compile to get their bread, and twenty fools extract, criticize, apologize, and satarize these compilations to get bread also, because they have no profession.''

Or better still, maybe I should heed constructive criticism in hopes that it will polish my literary efforts.

Future Plans

A novel lies on the back burner — sort of a ''Love Story'' motif based upon an experience during my medical residency. I also plan to do a second edition of *Modern Cardiology* and to author a book on exercise and the heart (for a lay audience) under the auspices of the American College of Physicians. Short stories will appear as they come to me, the most recent being ''Glimpses of a Season'' which is a chronicle of the Braves' 1977 baseball season from my vantage point. I'd also like to edit my father's letters sent home during World War I, giving copies to all family members, and to trace my Irish roots, for in the words of William James, ''We live forward, we understand backwards.''

* Bradley is severely retarded.

editorial
editorial
editorial

It Is Time for Medicine to Speak Up For an Old Friend

RECENT NEWS RELEASES indicate that research by a pharmaceutical manufacturing company has shown that an unusually large new gene may be transplanted into bacteria. The bacteria so treated may be subsequently induced into producing sizeable quantities of a new protein. The pharmaceutical company indicated that this research lays the groundwork for producing medically useful quantities of enzymes and hormones from these low order bacteria.

At the same time that the new, potentially valuable but undoubtedly costly research was being publicized, other less favorable news was being presented. The public was being told that the "monopolies" that brand-name, ethical drug producers have enjoyed for years on many high-revenue products were coming to an end, with expiration by 1980 of patent protection on 83 of the nation's leading prescription drugs. The public was also being told that 40 states and the District of Columbia, with help from model statutes prepared by the Federal Trade Commission, now have laws that promote the substitution of generic for brand-name prescription drugs. Concomitantly, the Department of Health, Education, and Welfare has been hard at work setting maximum costs that the Federal Government will pay for specific prescription drugs sold to Medicaid and Medicare patients. Our nation's ethical pharmaceutical manufacturers have in essence been depicted as monopolistic, profit-hungry ogres, bent upon seducing physicians' prescribing habits with lavish advertising and detailing campaigns and coercing the public into financing such ventures.

In view of continued governmental involvement in the regulation of the practices and profits of pharmaceutical manufacturing concerns in the United States, dating back to the Kefauver investigations of the early 1960s, significant attention on the part of the public and the medical profession has been focused upon this facet of health care in the United States. Allegations are continuously made that cast aspersions upon the drug manufacturers. Although no involved party is necessarily flawless in this confrontation, one should look at this situation from a realistic perspective.

"Historically, pharmaceutical businesses have impacted heavily on the length and quality of human life."

As a fundamental premise, one must recognize that the economy of the United States is based upon a capitalistic system of free enterprise. This system has produced the best health conditions and the highest standard of living in the world. One must not forget that the pharmaceutical manufacturing companies are commercial enterprises and that the purpose of such organizations is to make a profit. Quite legitimately and logically, these companies are not only entitled to a profit, they must also make a profit in order to survive.

Historically, pharmaceutical businesses have impacted heavily on the length and

quality of human life. Look at the record of the health program in which these businesses have played a vital part. At the time of the Roman Empire, life expectancy at birth was about 25 years. At the turn of this century, when William McKinley was President of the United States, life expectancy had increased to 42 years. Today it has reached well into the 70s. This increase in survival has been achieved primarily by scientific advancements in both medicine and public health. The pharmaceutical industry has played a significant role in this spectacular achievement. For example, the Eli Lilly Company's investment of a huge sum of money in an insulin plant in 1922 made the scientific discovery of insulin available to more than 1 million diabetics in America and millions more in other parts of the world. American pharmaceutical ingenuity made the relatively unknown substance penicillin available to the Armed Forces of the Allies and the civilian population in the World War II era. These ventures entailed significant financial risks, the application of many scientific skills, production skills, and astute business knowledge. Although their commercial risks were great, the stakes in human life were even greater, and ethical pharmaceutical manufacturers responded.

"Eli Lilly Company's investment of a huge sum of money in an insulin plant in 1922 made the scientific discovery of insulin available to [millions]. . . ."

Contemporary pharmaceutical research by the ethical drug industry no doubt occupies a large proportion of the total amount of medical research conducted in the United States. This research requires the employment of some of the best scientific minds in the nation and the investment of huge sums of money in fundamental investigations of many areas of medicine such as cardiovascular disease, cancer, mental illness, and the aging process. As is known in the oil well drilling business, there is never guaranteed success in any research project. No doubt there are thousands of failures for each success. This unquestionably entails financial risks of significant magnitude.

Chemists, microbiologists, and immunologists employed by pharmaceutical companies probably produce thousands of new chemical and biological compounds each year. Extensive research must then be done to determine what they can be used for in treating the myriad of human ailments. To provide the answers requires the skills of many trained specialists: pharmacologists, bacteriologists, pathologists, and physicians. Multiple batteries of screening tests must be carried out on many types of laboratory animals. Great wisdom, skill, and judgment are necessary for translating the action of the drugs on animals into a possible use among human beings with disease. The introduction of drugs (these often being foreign substances) into the human body chemistry requires great care to avoid dangerous reactions in man. Drugs must often be fed to particular species of laboratory animals during their entire life span (which may last several years) in order to ascertain their effect.

Directly implied in the previous description of pharmaceutical research is the fact that the cost of the drug is not easily determined. Raw material costs are obviously not difficult to determine, but ancillary costs in capital investment, financial risks, scientific personnel, business management, and product distribution are very great and difficult to evaluate. Because of the effects of inflation on research costs, the time and money involved in lengthy governmental approval processes, and the effects of competition cutting into profits, it has been estimated that the average new ethical drug costs as much as 55 million dollars to bring to the market place.

". . . it has been estimated that the average new ethical drug costs as much as $55 million to bring to the market place."

The most profound increase in the cost of medical care today other than inflation

has been in hospitalization costs, and this has been necessary because of the increased costs of food, labor, construction, new equipment, and maintenance. One need merely look at the dramatic reduction in bed requirements of the mental hospitals to realize that there has been no single enterprise more responsible for reduction of hospital costs than the drug industry. By virtue of the new drugs it develops, the periods of required hospitalization for patients are reduced.

It is most unfortunate that many of those who adversely criticize the drug industry are lacking in knowledge of its service to mankind and of the problems inherent in the competitive enterprise system. Many of these critics have apparently spent their careers within the confines of agencies and institutions, insulated from the heat of competitive enterprise. Although supported mainly by dollars earned by those in the capitalistic system, they yet condemn the practices of this industry.

". . . it becomes increasingly obvious that the very survival of mankind depends upon a continued organized research program that only a free enterprise system can support."

Let us look at the industry's record of achievement. At the turn of the century, it gave us aspirin and later barbiturates. Then came diphenylhydantoin for controlling seizures, and then meperidine, one of the most commonly used pain relievers. Next came vitamin B-12, the many broad spectrum antibiotics, cortisone, reserpine, chlorpromazine, and chlorothiazide, to mention only a few. Needless to say, the field of medicine today might still be in the dark ages were it not for the free enterprise system and our allies in the ethical pharmaceutical industry. A crucial portion of that which we do every day depends not only on the reliance, confidence, and trust that we place upon these allies, but upon their continued basic and applied research. Knowing what we know about the peculiar abilities of noxious elements in this world to adapt to and immunize themselves against the very medicaments that we daily use to protect ourselves against them, it becomes increasingly obvious that the very survival of mankind depends upon a continued organized research program that only a free enterprise system can support. Let us not forget our allies in this fight against disease, and let us lend our words of support when they need it most.

Arthur M. Smith, M.D.
Section of Urology
Medical College of Georgia
Augusta

Letter to the Editor

Pregnancy Editorial Applauded

Dear Sir:

I wish to applaud heartily your editorial in the *JMAG* for May and commend you for clinical alertness and gumption. It is admittedly difficult for parents to instill morality, what with our law-breaking society, but if they would have their children "not conformed to this world," they must try.

The very deserving articles by Dr. Witte and Dr. Hallum Jr. cannot accomplish their preventive effect when those who are taught in the various programs hear but fail to do. At base, such non-attainment relates to the current worship of humanism. Certainly, the *sine qua non* you point out demands primary consideration.

Yours,
Purcell Roberts, M.D.
Atlanta

president's letter



1979 Goal — A Rudder for MAG

On the lake recently, I saw a sailboat with a distressed crew making no progress. The boat had lost its rudder and was wallowing in the waves. I helped the crew reach their goal — the dock — with a simple tow so their boat could have its rudder repaired and get back on course.

This year, with your help, we are going to set goals and keep the MAG rudder steering a true course. The Executive Committee is meeting June 23 and 24 (Saturday and Sunday) for a special planning meeting. After we set our goals for this year, we are going to assign priorities. These goals initially will be short-ranged but will eventually develop into long-range plans.

I am very enthusiastic and excited about this project of priority goal-setting. I am asking the Executive Committee, the Board of Directors, the House of Delegates and each of *you* to *unite* and help us secure a permanent rudder on the S.S. MAG.

Earnest C. Atkins

Earnest C. Atkins, M.D.
President, MAG

The Maker

Examining a Few Myths About Prescribing.



Increasing pressure is being put on the practicing physician to prescribe drugs generically. You are told that brand-name products are universally "expensive" and generic versions are relatively "cheap." To make this case, the most extreme (rather than typical) price differentials are cited. Thus, consumers are led to believe that such differentials are commonplace. Even your knowledge and your motives as a physician are questioned.

Understandably, these views have created myths. We think it's time to examine them in the light of all the facts and ramifications.

MYTH: There are no differences in quality and performance between brand-name products and their generic counterparts. The corollary is that there are no differences among products made by high-technology, quality-conscious, research-based companies and those made by commodity-type suppliers.

FACT: The Food and Drug Administration does a good job in monitoring a generally excellent drug supply. Still, it has nowhere near the resources to guarantee the quality and bioavailability of all marketed products at any given time. Just a few months ago, for example, it noted that batches of tetracycline HCl capsules which met official monograph requirements were not bioequivalent to a reference product. As y know, there is substant literature on this subje affecting many drugs, i cluding such antibiotic as tetracycline and erythromycin. The record drug recalls and court actions affirms strongl that there are differenc among pharmaceutical companies and their products. Research-intensive companies have far better records than those that do no re search and may practic minimum quality assu ance.

MYTH: Industry favors only "expensive" brand names and denigrates all generics.

FACT: PMA companies make 90 to 95 percent the drug supply, includ ing, therefore, most of t generics. Drug nomenclature is not the impor tant point; it's the comp tence of the manufacturer and the integrity the product that count.

Matters.

YTH: Generic options al-ost always exist.

ACT: About 55 percent prescription drug ex-enditure is for single-urce drugs. This eans, of course, that for ly 45 percent of such penditure, is a generic escribing option avail-le.

YTH: Generic escriptions are filled with expensive generics, thus ving consumers large ms of money.

ACT: Market data show at you invariably escribe—and pharma-sts dispense—both rand and generically beled products from nown and trusted urces, in the best inter-st of patients. In most ases the patient receives proven brand product. avings from voluntary r mandated generic escribing are grossly xaggerated.

MYTH: Drugs account for a major portion of the rise in health care costs.

FACT: Drugs represent a very small part of such costs. The amount of the health care dollar spent for prescription drugs was about 12 cents in 1967; today it is about 8 cents. And you as a physician are most conscious of how drug therapy can cut hospitalization, avert surgery, reduce office visits and keep patients on the job.

MYTH: Government intrusions into the marketplace will save tax money.

FACT: Government schemes always cost the taxpayer something, and the costs often exceed the benefits. Certainly, any federal "help," such as lists of wholesale drug prices sent to all physicians and pharmacists, will be no exception. Just think of the expense of keeping them current! Moreover, wholesale prices are poor guides to actual transaction prices and even worse guides to retail prices.

The PMA Position

We believe your freedom to prescribe, either by generic or brand name, should be totally unabridged. Otherwise, your prescribing prerogatives and your relationships with patients will be seriously impaired.

The maker does matter

After the myths about price and equivalency have been shattered, one fact stands out more clearly than ever: *The maker does matter.* As always, your best guide to drug therapy for your patients is to select products—both brands and generics—from manufacturers with credentials and performance records you have come to respect.

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legal page
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Prescription Drugs Under Federal and State Law

ROBERT N. BERG, *Atlanta**

When must a prescription be given in writing? When, if ever, may a written prescription be signed by a nurse or other employee acting for the prescribing physician? When, if ever, can a prescription be "called in" by the prescribing physician's nurse or other employee?

The answers to these questions are governed by both federal and state laws and regulations. While federal and state authorities are, for the most part, conceptually similar, the Georgia law and regulations appear to be more restrictive with respect to the allowable activities which a nurse or other employee can perform on behalf of a physician in connection with ordering prescription drugs.

Requirements Under Georgia Law

The prescribing, ordering, and dispensing of prescription drugs are primarily governed under Georgia law by the "Georgia Controlled Substances Act," (the "Georgia Act"),[1] and the regulations promulgated thereunder by the Georgia State Board of Pharmacy (the "Board of Pharmacy Rules").[2]

Pursuant to the Georgia Act, five schedules of "controlled substances" are established,[3] known as Schedules I, II, III, IV, and V. The drugs listed on these schedules can be generally distinguished by their potential for abuse as found by the Board of Pharmacy, with Schedule I drugs or other substances having the highest potential for abuse and Schedule V drugs having the least potential for abuse.

The requirements under the Georgia Act and the Board of Pharmacy Rules with respect to the prescribing, ordering, and dispensing of prescription drugs depend upon the schedule in which the drugs are classified. For example, Schedule I drugs may not be dispensed pursuant to either written or oral prescriptions, as these drugs are defined as having no currently accepted medical use in treatment in the United States. On the other hand, Schedules III, IV, and V drugs[4] can be dispensed pursuant to either written or oral prescriptions. In between these two extremes, Schedule II drugs[5] must be dispensed pursuant to a written prescription, with two exceptions: (1) Schedule II drugs dispensed directly to an ultimate user by a physician or institution registered under the Georgia Act to dispense controlled substances (other than a pharmacy or pharmacist), may be dispensed without a written prescription; and (2) Schedule II drugs can be dispensed upon oral prescription in an "emergency situation,"[6] if the oral prescription is promptly reduced to writing by the prescribing physician and filed with the dispensing pharmacy or pharmacist.

* Prepared at the request of the Medical Association of Georgia. Mr. Berg is an associate in the firm of Powell, Goldstein, Frazer & Murphy, General Counsel to the Association, 1100 C & S National Bank Building, Atlanta, GA 30303.

In those instances where written prescriptions are either required under Schedule II or voluntarily utilized under Schedules III, IV, or V, there are formal requirements set out in the Board of Pharmacy Rules.[7] The written prescription must contain at least the full name and address of the person for whom the drug is prescribed, the kind and quantity of the drug, the directions for taking it, and the full signature, name, address, and Federal Registration number of the prescribing physician. In addition, the physician is required to sign the prescription in the same manner as he would sign a check or legal document. Moreover, in situations where an oral prescription is not permitted (e.g., Schedule II drugs in situations not involving the two exceptions set out above), the prescription must be written in ink or indelible pencil or typewriter and must be manually signed by the prescribing physician. In that context, the prescription may be typed or written up for the signature of the physician by a secretary or agent, but the physician is responsible in all cases where the prescription does not conform in all essential respects to the law and regulations.

In those instances where oral prescriptions can be utilized, the "practitioner issu(ing) an oral prescription" is required to supply the information described in the preceding paragraph to the pharmacist,[8] and the pharmacist who fills the oral prescription must place on the prescription all of the information given to him by the prescribing physician.

In light of the requirements of the Georgia Act and the Board of Pharmacy Rules as described above, it appears that a nurse or other employee is clearly prohibited under Georgia law from signing a physician's signature to a written prescription. In addition, a nurse or other employee appears to be prohibited under Georgia law from calling a pharmacist with an oral prescription upon the orders of the prescribing physician, since such a procedure is not expressly authorized under either the Georgia Act or the Board of Pharmacy Rules, and since the practitioner issuing the prescription, and not someone acting on his or her behalf, is required under the law and regulations to furnish the appropriate information to the pharmacist in connection with an oral prescription.[9]

Requirements Under Federal Law

The prescribing, ordering, and dispensing of prescription drugs is primarily governed under federal law by the "Controlled Substances Act" (the "Federal Act"),[10] and the regulations promulgated thereunder (the "Federal Regulations").[11]

In general, the Federal Act is much like the Georgia Act. Controlled substances are divided into five schedules (I-V), and the requirements as to the type and contents of prescriptions for controlled substances depend upon the schedule in which the substances are classified. Like their Georgia counterparts, the Federal Act and Regulations authorize the dispensing of prescription drugs pursuant to either oral or written prescriptions for drugs listed on Schedules III, IV, and V; Schedule II drugs can only be dispensed pursuant to a written prescription, subject to the same exceptions as found in the Georgia Act for direct dispensing by a registered physician (other than a pharmacy or pharmacist) and for dispensing in emergency situations pursuant to oral prescriptions.

The requirements under the Federal Act and Regulations with respect to the content of written prescriptions also parallel Georgia law. Thus, all written prescriptions must be signed by the prescribing physician and therefore cannot be signed by a nurse or other agent.

In those situations where oral prescriptions may be used, the federal law is more liberal than the Georgia law, in that it specifically authorizes the procedure whereby "a prescription issued by an individual practitioner may be communicated to a pharmacist by an employee or agent of the individual practitioner."[12] Consequently, the Federal Act and Regulations expressly authorize a nurse (or any other agent of the prescribing physician) to call in an oral prescription to a pharmacist upon the prescribing physician's orders.[13]

Conclusion

In summary, it is clear both under the Georgia Act, the Board of Pharmacy Rules, and the Federal Act and Regulations that a nurse is prohibited from signing the prescribing physician's name to a written prescription. In addition, while it appears that the law in Georgia prohibits a nurse from calling in an oral prescription to a pharmacist upon the orders of the prescribing physician, this procedure is specifically authorized under the federal regulations. Nevertheless, since a person complying with the federal regulations with respect to oral prescriptions could still be liable for a violation of the Georgia Act and the Board of Pharmacy Rules,[14] it appears that the more restrictive Georgia law must be followed in connection with the ordering of oral prescriptions.

Notes

1. *Ga. Code Ann.* §79A-801 *et seq.*
2. Chapter 480-22 of the Rules of Georgia State Board of Pharmacy.
3. *Ga. Code Ann.* §79A-805.
4. Schedule III lists those drugs or other substances which, although having a currently accepted medical use, may, if abused, lead to moderate or low physical dependence or high psychologic dependence. Schedule IV lists those drugs or other substances which, although having a currently accepted medical use, may, if abused, lead to limited physical dependence or psychologic dependence. Schedule V lists those drugs or other substances which have a low potential for abuse, and, although having a currently accepted medical use, may, if abused, lead to limited physical dependence or psychologic dependence (relative to Schedule IV drugs).
5. Schedule II lists those drugs or other substances which have a high potential for abuse and, although having a currently accepted medical use (either with or without restrictions), may, if abused, lead to severe physical or psychologic dependence.
6. The term "emergency situation" is left undefined in both the Georgia Act and the Board of Pharmacy Rules.
7. Section 480-22-.01(1) of the Board of Pharmacy Rules.
8. Section 480-22-.01(2) of the Board of Pharmacy Rules.
9. In addition to the Georgia Act, the prescribing, ordering, and dispensing of prescription drugs are also governed by the Georgia "Dangerous Drug Act," *Ga. Code Ann.* §79A-701 *et seq.* Pursuant to this Act, any drug which may be dispensed only upon prescription under the "Federal Food, Drug, and Cosmetic Act" is a "dangerous drug" under Georgia law and may only be dispensed upon the oral or written prescription of a practitioner. As to the question of whether an oral prescription for a "dangerous drug" can be "called in" by the prescribing physician's nurse or other employee, the answer appears to be the same as with oral prescriptions for controlled substances, in that the definition of "practitioner" or "practitioner of the healing arts" (the only persons authorized to prescribe "dangerous drugs") under the Georgia Dangerous Drug Act is restricted to physicians, dentists, veterinarians, and persons licensed to use, mix, prepare, dispense, prescribe, and administer drugs. Consequently, assuming that a "dangerous drug" was not listed on any of the schedules of "controlled substances," it would appear that a nurse or other employee, not being a "practitioner," would be prohibited under the Georgia Dangerous Drug Act from calling a pharmacist with an oral prescription upon the orders of the prescribing physician.
10. 21 U.S.C. §801 *et seq.*
11. 21 C.F.R. Part 1306.
12. 21 C.F.R. §1306.03(b).
13. In addition to the Federal Act, the prescribing, ordering, and dispensing of prescription drugs are also governed by the "Federal Food, Drug, and Cosmetic Act," 21 U.S.C. §301 *et seq.* Pursuant to this Act, certain habit-forming drugs and certain drugs considered to be potentially harmful to human beings because of their toxicity can only be dispensed (i) upon a written prescription of a practitioner licensed by law to administer such a drug, or (ii) upon an oral prescription of such practitioner which is promptly reduced to writing and filed by the pharmacist. 21 U.S.C. §353(b)(1).
14. 21 C.F.R. §1307.02.

New Developments in Chemotherapy of Genitourinary Cancers

LEONARD H. BRUBAKER, M.D., *Augusta**

DEVELOPMENT OF NEW DRUGS, drug combinations, and dosage schedules for the treatment of genitourinary cancers have markedly improved the prognosis of these patients, making it possible to talk about a chemotherapeutic cure of some types of tumors, particularly testicular and ovarian, which formerly were usually fatal. To a large degree these recent advances are dependent on the availability of a new, toxic, and expensive drug, cis-diamminedichloroplatinum (cis-platinum), which has been released for routine medical use. Multimodality therapy is also essential to maximize the chance of a long remission or cure. On the other hand, these treatments have sometimes severe side effects, and they must be used with great caution.

In the mid-1960's, Rosenberg and Van Camp[1] accidentally discovered that bacterial replication was inhibited near a platinum electrode. Further investigation of platinum-containing coordination compounds revealed that they had potent antitumor activity in animals.[2, 3] Subsequent clinical trials in humans have disclosed that the compound, cis-platinum, has a broad spectrum of antitumor activity which is particularly noteworthy in patients with genitourinary tumors. It was also found, however, that this drug has significant side effects, such as nephrotoxicity, nausea, and vomiting which can be severe enough to require modification of drug doses or discontinuation. The drug also has bone marrow toxicity but not as severe as many other anticancer drugs. This has made it possible to combine cis-platinum with other anticancer drugs having predominantly marrow toxicity, so that the dose of each drug need not reach limiting toxic levels, and their overall antitumor effects can be greatly enhanced.

Such a combination has made the greatest impact in the treatment of disseminated testicular cancer other than seminoma, which is best treated with radiotherapy. Lawrence Einhorn and his co-workers at the University of Indiana have shown that the combination of cis-platinum, vinblastine, and bleomycin produced a response in each of the 47 patients with advanced testicular cancer that were evaluated.[4] Three quarters of these were rendered apparently disease-free by the combination. Subsequent surgery to remove residual disease produced a disease-free status in another five patients. Three patients, who had advanced pulmonary metastases, died not long after the start of chemotherapy, apparently from the extent of disease rather than from drug toxicity. It now appears that a large number of these patients may have permanent cures, although more time is necessary to be sure. This represents a marked alteration of the inevitably fatal natural history of this advanced disease.

Carcinoma of the ovary is also responsive to cis-platinum. Several investigational combinations have now produced an apparently increased response rate in

* Dr. Brubaker is a Professor of Medicine at the Medical College of Georgia in Augusta, GA 30912. Prepared at the request of the Georgia Division, American Cancer Society. Others wishing to contribute papers to this page are invited to send them to David B. Roberts, M.D., 2400 13th St., Columbus, GA 31906.

ovarian carcinoma over the response rate of Alkeran alone. These reports are preliminary, and no combination has achieved prominence at this point.

Bladder carcinoma has responded dramatically to cis-platinum, and the experimental use of combination chemotherapy in this condition is just getting underway. Investigations of cis-platinum-containing combination chemotherapy are also beginning in other genitourinary tumors.

Radiation therapy has been frequently used to help control genitourinary cancers for a long time, but with the advent of more effective chemotherapy combinations, the proper placement of radiation therapy as a part of multimodality treatment of these cancers is in a state of flux. It is now clear, for example, that radiation therapy should not be given to patients with testicular carcinoma prior to the use of chemotherapy, because the effect of radiation therapy on the bone marrow does not permit full doses of potentially curable chemotherapy to be given. The same may also be true in ovarian carcinoma. With most other genitourinary tumors, however, radiation therapy is still used before chemotherapy. Certainly radiation therapy has a well-established place in the palliative treatment of bone and other metastases, and this should be kept in mind for patients with advanced malignancies of any kind.

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A Current Appraisal of Coronary Bypass Surgery

CHARLES R. HATCHER JR., M.D., *Atlanta**

In the past decade, it has become apparent that direct myocardial revascularization is of significant benefit to many patients with coronary artery disease. As a result, saphenous vein bypass graft procedures were among the most frequently performed surgical operations in the United States last year. The widespread acceptance of bypass surgery is based on several established facts.[1] First, bypass surgery is performed at acceptably low risk, 1-2% in major centers with large series.[2] Perioperative infarction rates have declined steadily with increased surgical and anesthestic experience and improved techniques for myocardial preservation (under 5% in 1978).[3] Sympomatic relief of angina pectoris following bypass surgery has been quite impressive. Over two-thirds of the patients have no angina, and approximately 90% experience less angina following surgery.[4] This clinical improvement correlates very well with vein patency rates, which at present approximates 90% in our institution. Quality of life is improved markedly in most bypass patients, a benefit not fully appreciated in all circles. Increased exercise tolerance and physical activity are reported by 80% of our patients, and in a lesser number undergoing re-catheterization, a quantitative improvement in ventricular function can be demonstrated.

With such favorable results being achieved with bypass surgery, it is unfortunate that some controversy has recently developed concerning the true value of bypass surgery. Throughout the development period there has been a legitimate concern regarding the financial and logistical implications of these procedures. When the Veterans Administration Cooperative Study, which excluded left main disease, concluded that there was no significant difference in life expectancy in selected patients with stable angina treated medically or surgically, criticism of bypass surgery mounted. The obvious and accepted benefits of the surgery were lost in discussion of this single topic of prolongation of life.[5]

While bypass surgery would be completely justified on the grounds of other benefits, it is fortunate that data are now available showing prolongation of life for patients with certain subsets of coronary artery disease treated surgically and compared to patients given medical therapy.[6]

Our own data shows that among these sub-sets are left main disease, triple vessel disease, and double vessel disease.[1] Improved survival is suggested but not proven statistically for patients with isolated obstruction of the LAD proximal to the septal perforators. Specifically, cumulative survival for our total surgical group at 36 months was 91%. Cumulative survival by extent of disease was: single vessel 98.1%, double vessel 95.1%, triple vessel 89.7%, and left main 91.6%. The effects

* Dr. Hatcher is from the Joseph B. Whitehead Department of Surgery, Division of Thoracic and Cardiovascular Surgery, Emory University School of Medicine, Atlanta, GA 30322. Articles for this page are prepared at the request of the Physician Education Committee of the Georgia Heart Association, Broadview Plaza, Level C, 2581 Piedmont Rd., NE, Atlanta, GA 30324.

of preoperative ventricular function on patient survival is of the utmost importance — with normal or mildly impaired ventricular function cumulative survival 97.1% — and survival dropped to 85.6% with significant abnormality in ventricular function.

All of these survival rates compare favorably with the survival rates for any reported comparable medical series.[7] This data will become more valid as the period of follow-up lengthens.

Remarkable relief of angina pectoris, improved quality of life, increased levels of activity, and improved survival of patients undergoing bypass surgery fully justify the present aggressive surgical approach to selected patients with coronary artery disease.

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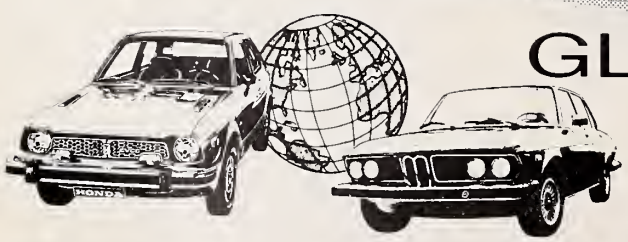
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Serum K^+ and BUN should be checked periodically particularly in the elderly, diabetics, and those with suspected or confirmed renal insufficiency (see Warnings). If hyperkalemia develops, substitute a thiazide alone.



Before prescribing, see complete prescribing information in SK&F Co. literature or *PDR*. A brief summary follows:

* **WARNING**
This drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual. If this combination represents the dosage so determined, its use may be more convenient in patient management. Treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

Contraindications: Further use in anuria, progressive renal or hepatic dysfunction, hyperkalemia. Pre-existing elevated serum potassium. Hypersensitivity to either component or other sulfonamide-derived drugs.

Warnings: Do not use potassium supplements, dietary or otherwise, unless hypokalemia develops or dietary intake of potassium is markedly impaired. If supplementary potassium is needed, potassium tablets should not be used. Hyperkalemia can occur, and has been associated with cardiac irregularities. It is more likely in the severely ill, with urine volume less than one liter/day, the elderly and diabetics with suspected or confirmed renal insufficiency. Periodically, serum K^+ levels should be determined. If hyperkalemia develops, substitute a thiazide alone, restrict K^+ intake. **Associated widened QRS complex or arrhythmia requires prompt additional therapy.** Thiazides cross the placental barrier and appear in cord blood. Use in pregnancy requires weighing anticipated benefits against possible hazards, including fetal or neonatal jaundice, thrombocytopenia, other adverse reactions seen in adults. Thiazides appear and triamterene may appear in breast milk. If their use is essential, the patient should stop nursing. Adequate information on use in children is not available.

Precautions: Do periodic serum electrolyte determinations (particularly important in patients vomiting excessively or receiving parenteral fluids). Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics or those with suspected or confirmed renal insufficiency. Watch for signs of impending coma in severe liver disease. If spironolactone is used concomitantly, determine serum K^+ frequently; both can cause K^+ retention and elevated serum K^+. Two deaths have been reported with such concomitant therapy (in one, recommended dosage was exceeded, in the other serum electrolytes were not properly monitored). Observe regularly for possible blood dyscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving triamterene, and leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with thiazides. Triamterene is a weak folic acid antagonist. Do periodic blood studies in cirrhotics with splenomegaly. Antihypertensive effect may be enhanced in postsympathectomy patients. Use cautiously in surgical patients. The following may occur: transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), hyperuricemia and gout, digitalis intoxication (in hypokalemia), decreasing alkali reserve with possible metabolic acidosis. 'Dyazide' interferes with fluorescent measurement of quinidine.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis, rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting, diarrhea, constipation, other gastrointestinal disturbances. Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and, rarely, allergic pneumonitis have occurred with thiazides alone.

Supplied: Bottles of 100 and 1000 capsules; Single Unit Packages of 100 (intended for institutional use only).

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...in the functional bowel/irritable bowel syndrome*

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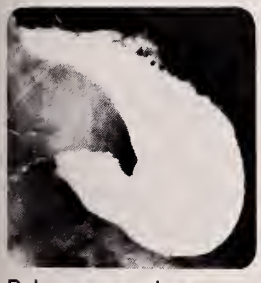
10 mg. capsules, 20 mg. tablets,
10 mg./5 ml. syrup, 10 mg./ml. injection

helps control abnormal motor activity
with minimal anticholinergic side effects†

Demonstrated smooth muscle relaxant activity.

In this double-blind study, twenty patients having G.I. series and exhibiting spasm were randomly selected to receive either 2 cc. of Bentyl or sodium chloride intramuscularly. Ten minutes after the injection another radiograph was taken . . .

. . . Bentyl produced definite relaxation in 8 of 10 patients. The sodium chloride produced relaxation in only 3 of 10. No side effects occurred in either group of patients.



Pylorospasm has almost totally blocked passage of barium meal.



Barium meal beginning to pass 10 minutes after intramuscular injection of 20 mg. Bentyl.

"The correlation of spasm relief and drug given was excellent."

*This drug has been classified "probably" effective in treating functional bowel/irritable bowel syndrome.

†See Warnings, Precautions and Adverse Reactions.

See following page for prescribing information.

Reference:
King, J.C. and Starkman, N.M.: Evaluation of an antispasmodic. Double-blind evaluation to control gastrointestinal spasms occurring during radiographic examination. A preliminary report. Western Med. 5:356-358, 1964.

Merrell

8-4420 (Y736A) MNR-804

Bentyl®

(dicyclomine hydrochloride USP)

Capsules, Tablets, Syrup, Injection

AVAILABLE ONLY ON PRESCRIPTION

Brief Summary

INOICATIONS

Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FOA has classified the following indications as "probably" effective:

For the treatment of functional bowel/irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis.

THESE FUNCTIONAL OISOROERS ARE OFTEN RELIEVEO BY VARYING COMBINATIONS OF SEOATIVE, REASSURANCE, PHYSICIAN INTEREST, AMELIORATION OF ENVIRONMENTAL FACTORS.

For use in the treatment of infant colic (syrup).

Final classification of the less-than-effective indications requires further investigation.

CONTRAINOICATIONS: Obstructive uropathy (for example, bladder neck obstruction due to prostatic hypertrophy); obstructive disease of the gastrointestinal tract (as in achalasia, pyloroduodenal stenosis); paralytic ileus, intestinal atony of the elderly or debilitated patient; unstable cardiovascular status in acute hemorrhage; severe ulcerative colitis; toxic megacolon complicating ulcerative colitis; myasthenia gravis. WARNINGS: In the presence of a high environmental temperature, heat prostration can occur with drug use (fever and heat stroke due to decreased sweating). Oiarrhea may be an early symptom of incomplete intestinal obstruction, especially in patients with ileostomy or colostomy. In this instance treatment with this drug would be inappropriate and possibly harmful. Bentyl may produce drowsiness or blurred vision. In this event, the patient should be warned not to engage in activities requiring mental alertness such as operating a motor vehicle or other machinery or perform hazardous work while taking this drug. PRECAUTIONS: Although studies have failed to demonstrate adverse effects of dicyclomine hydrochloride in glaucoma or in patients with prostatic hypertrophy, it should be prescribed with caution in patients known to have or suspected of having glaucoma or prostatic hypertrophy. Use with caution in patients with: Autonomic neuropathy. Hepatic or renal disease. Ulcerative colitis. Large doses may suppress intestinal motility to the point of producing a paralytic ileus and the use of this drug may precipitate or aggravate the serious complication of toxic megacolon. Hyperthyroidism, coronary heart disease, congestive heart failure, cardiac arrhythmias, and hypertension. Hiatal hernia associated with reflux esophagitis since anticholinergic drugs may aggravate this condition.

Do not rely on the use of the drug in the presence of complication of biliary tract disease. Investigate any tachycardia before giving anticholinergic (atropine-like) drugs since they may increase the heart rate. With overdosage, a curare-like action may occur. AOVERSE REACTIONS: Anticholinergics/antispasmodics produce certain effects which may be physiologic or toxic depending upon the individual patient's response. The physician must delineate these. Adverse reactions may include xerostomia; urinary hesitancy and retention; blurred vision and tachycardia; palpitations; mydriasis; cycloplegia; increased ocular tension; loss of taste; headache; nervousness; drowsiness; weakness; dizziness; insomnia; nausea; vomiting; impotence; suppression of lactation; constipation; bloated feeling; severe allergic reaction or drug idiosyncrasies including anaphylaxis; urticaria and other dermal manifestations; some degree of mental confusion and/or excitement, especially in elderly persons; and decreased sweating. With the injectable form there may be a temporary sensation of lightheadedness and occasionally local irritation. OOSAGE ANO AOMINISTRATION: Dosage must be adjusted to individual patient's needs.

Usual Dosage: Bentyl 10 mg. capsule and syrup: *Adults:* 1 or 2 capsules or teaspoonfuls syrup three or four times daily. *Children:* 1 capsule or teaspoonful syrup three or four times daily. *Infants:* ½ teaspoonful syrup three or four times daily. (May be diluted with equal volume of water.) Bentyl 20 mg.: *Adults:* 1 tablet three or four times daily. Bentyl Injection: *Adults:* 2 ml. (20 mg.) every four to six hours intramuscularly only. NOT FOR INTRAVENOUS USE. MANAGEMENT OF OVERDOSE: The signs and symptoms of overdose are headache, nausea, vomiting, blurred vision, dilated pupils, hot, dry skin, dizziness, dryness of the mouth, difficulty in swallowing, CNS stimulation. Treatment should consist of gastric lavage, emetics, and activated charcoal. Barbiturates may be used either orally or intramuscularly for sedation but they should not be used if Bentyl with Phenobarbital has been ingested. If indicated, parenteral cholinergic agents such as Urecholine® (bethanecol chloride USP) should be used.

Product Information as of October, 1978.

Injectable dosage forms manufactured by CONNAUGHT LABORATORIES, INC., Swiftwater, Pennsylvania 18370 or TAYLOR PHARMACAL COMPANY, Oecatur, Illinois 62525 for MERRELL-NATIONAL LABORATORIES, Division of Richardson-Merrell Inc., Cincinnati, Ohio 45215, U.S.A.

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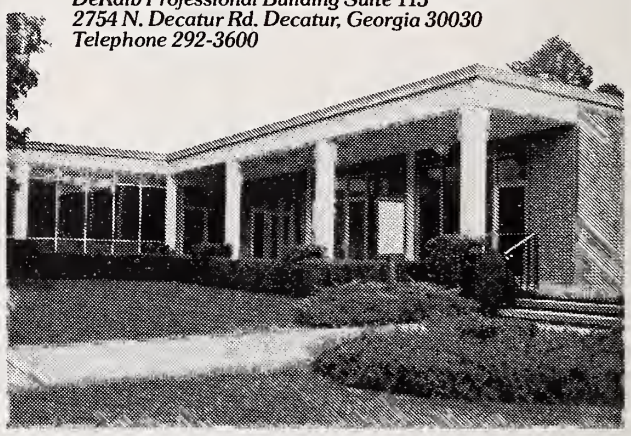
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1462 Montreal Rd., Ste. 214, Tucker 30084

Bingle, James F., Dougherty—N2—IM
Lee County Primary Health Care, Leesburg 31763

Brennan, James A., Troup—N2—IM
303 Smith St., LaGrange 30240

Carter, Yancey Franklin, Tift—ACT—GP
1223 E. McPherson, Nashville 31639

Chubb, Nicholas C., Richmond—ACT—P
VA Hospital, Augusta, GA 30904

Cohen, Michael Joseph, Richmond—N2—RHU
1109 Medical Center Dr., Ste. 8-B, Augusta, GA 30909

Everidge, George J., Muscogee—N2—OBG
1900 Hamilton Rd., Columbus 31904

Ferguson, Frederick Campbell, Richmond—ACT—U
3623 J Dewey Gray Cir., Ste. 313, Augusta 30909

Glass, Clark H., Cobb—N2—ORS
652 Church St., Marietta 30060

Hagler, Mary Anne Tyler, Richmond—N2—FP
1600 Winter St., Augusta 30904

Hall, Stanley W., Jr., Troup—N2—OPH
303 Smith St., LaGrange 30240

Hawkins, James H., Muscogee—I&R—FP
P.O. Box 951, Columbus 31902

Hawkins, John C., Richmond—I&R—NS
Neurosurgery Section, Medical College of Georgia, Augusta 30901

Holloway, John T., Ware—ACT—GP
1101 Church St., Waycross 31501

Holsinger, James Wilson Jr., Richmond—ACT—CDS
VA Hospital, Augusta 30904

Hotz, James A., Dougherty—N2—IM
Lee County Primary Health Care, Leesburg 31763

Johnson, John Kim, St. John's Parish—N2—GP
New Station Rd., Box 37, Ludowici 31316

Kassam, Shiraz H., Richmond—ACT—OBG
Dept. of Ob-Gyn, Medical College of Georgia, Augusta 30901

Kelley, John Walter, Richmond—ACT—CDS
1021 15th St., Ste. 1, Augusta 30901

Kenny, William R., MAA—ACT—PUD
1968 Piedmont Rd., Atlanta 30309

Marcus, Donald Jay, Richmond—ACT—N
VA Hospital, Neurology Service, Augusta 30904

McRae, Donald Roswell III, Richmond—ACT—OBG
1512 Anthony Rd., Augusta 30904

Miller, James W., Ga. Med. Soc.—ACT—CD
803 E. 70th St., Ste. 103, Savannah 31405

Navuluri, Someswara Naidu, Richmond—I&R—P
Dept. of Psychiatry, Medical College of Georgia, Augusta 30901

Neal, Ruth E., Richmond—N2—R
Talmadge Memorial Hospital, Augusta 30901

Reese, Norman O., Colquitt—ACT—AN
P.O. Box 427, Moultrie 31768

Richbourg, Henry R., Tift—ACT—FP
1223 E. McPherson, Nashville 31639

Settle, Paul C., Muscogee—I&R—FP
P.O. Box 951, Columbus 31902

Sherman, Stanley W., DeKalb—N1—IM
495 Winn Way, Ste. B-260, Decatur 30030

Smith, Arnold G., Meriwether-Harris-Talbott—N1—OS
Ga. Warm Springs Hospital, Warm Springs 31830

Story, Stacy H. III, Richmond—N2—AN
2712 Wellington Dr., Augusta 30909

Taluyo, Lutgarda I., Baldwin—A—US
Central State Hospital, Milledgeville 31062

Tedesco, Francis Joseph, Richmond—ACT—GE
Section of Gastroenterology, Medical College of Georgia, Augusta 30901

Tieman, Michael E., MAA—A—GS
1051 Rosedale Rd., NE, Atlanta 30306

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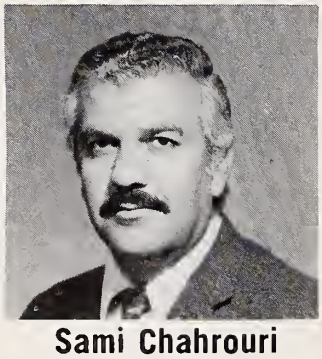
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The average premium for ages 35 through 39 is $261 annually. These premiums can be further reduced by applying any dividends toward the premium payments.

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PERSONALS

First District

Edgar J. Filson, M.D., past chief of staff at Candler General Hospital in Savannah, addressed the Candler Hospital Association on Thursday, March 29.

At the Community Cardiovascular Council quarterly breakfast meeting at Candler General Hospital in April, **James C. Metts Jr., M.D.,** was presented with a Resolution passed by Georgia's House of Representatives. The Resolution commended him for his 10 years of work in the field of cardiovascular disease.

Ray Webb, M.D., of Springfield, was recently named a diplomate of the American Board of Family Practice.

Third District

The Americus Lions Club recently honored **T. J. Rundle, M.D.,** with a plaque for his assistance in and contributions to the Lions Sight Conservation Program.

Fifth District

Ed Aderholt, M.D., an anesthesiologist at Piedmont Hospital in Atlanta, ran the Boston Marathon this year in 4 hours, 7 minutes, and 48 seconds.

Young W. Ahn, M.D., of Atlanta, was recently elected to Fellowship in the American College of Obstetricians and Gynecologists.

William Collins, M.D., an Atlanta orthopedic surgeon, spoke to the Statesboro Rotary Club on April 2.

On April 1, **Hoyt W. Crump, M.D.,** moved his practice from Atlanta to Royston.

William C. McGarity, M.D., of Atlanta is the author of a new surgical-technique film to be offered by the American College of Surgeons to physicians and medical students training around the world. His film is about a condition associated with increased activity of the parathyroid glands.

Sixth District

On April 4, **Harold Alfert, M.D.,** a urologist, opened his practice in Americus.

The Auxiliary to the Bibb County Medical Society honored 12 retiring physicians at a luncheon March 20. Those honored were: **George Alexander, M.D.,** family practice; **Earl S. Avant, M.D.,** anesthesiology; **William H. Holden, M.D.,** plastic surgery; **Lemuel James, M.D.,** family practice; **O. F. Keen, M.D.,** surgery; **Tom Ross, M.D.,** cardiology; **Edroe Stamps, M.D.,** urology; **Robert Walker Jr., M.D.,** public health and family practice.

Two MAG members have opened their offices in Zebulon. They are **L. L. Allen, M.D.,** and **Douglas Head Jr., M.D.**

Seventh District

William F. Wieland, M.D., an Atlanta physician addressed the 5th annual Career Women's Seminar, March 20-21, at the World Congress Center in Atlanta. His topic was on the stress involved in the career of the working wife and mother.

Tenth District

William Bonner, M.D., an Athens pediatrician, was selected to narrate the Carl Sandburg tribute to Abraham Lincoln, "A Lincoln Portrait," in the premiere performance of the Athens Symphony during the Athens Festival of the Arts on April 29.

James Polhill, M.D., of Louisville has recently been named a diplomat of the American Board of Family Practice.

SOCIETIES

At their May meeting, the members of the **Cobb County Medical Society** heard Art Eckman, Sports Director of 11 Alive News.

Louis W. Sullivan, M.D., Dean and Director of the Morehouse College School of Medicine, spoke to the members of the **DeKalb County Medical Society** at their April meeting. He spoke on "Advances in Medical Education."

DEATHS

W. G. Talbert Jr.

W. G. Talbert Jr., M.D., aged 64, died on April 4, after a brief illness.

Dr. Talbert was a native of Decatur County but had lived in Warner Robins since 1954 when he established the area's first hospital, Warner Robins Hospital and Clinic.

Dr. Talbert formerly served as chief of staff at the Houston County Hospital and was a member of the advisory board of Blue Cross/Blue Shield.

Dr. Talbert was a former chairman of the Administrative Board of First United Methodist Church. He was a member of the American Academy of Family Physicians, the American Medical Association, the Medical Association of Georgia, and the Peachbelt Medical Association, the Gridiron Club of the University of Georgia, and an honorary member of the Georgia Bulldogs Club.

He served for several years as chairman of the Houston County Board of Education and following his retirement from the post was named Man of the Year for 1976 by the Warner Robins Chamber of Commerce. He was an active member of the Warner Robins High School Touchdown Club and had served as the team's physician for a number of years.

Survivors include his wife, two sons, three sisters, three stepsons, and two grandchildren.

Ruben S. O'Neal

Ruben S. O'Neal, M.D., died April 10 at the age of 92. He had served as a member of LaGrange City Council from 1923-1924 and was mayor of the city from 1934-1950. He was a member of the medical staff of West Georgia Medical Center since its inception.

In 1962, Dr. O'Neal was honored by the MAG for 50 years of service and in 1969 was elected as MAG's "Practicing Physician of the Year."

In 1976, Governor Busbee appointed him as a full-time honorary member of the Governor's staff.

Duluth Professional Park

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Born in Harris County in 1886, Dr. O'Neal graduated from the University of Georgia School of Medicine in 1911. He served in the U.S. Army Medical Corps in 1917 and 1918 and was attached to the British Army. He was a charter president of the LaGrange Lions Club, a member of the First Baptist Church of LaGrange, and a past chairman of the Board of Deacons.

Survivors include his son, four grandchildren, and eight great-grandchildren.

Medicaid—To Participate or Not to Participate

The Medical Association of Georgia (MAG) affirms the right of the individual physician's freedom in the practice of medicine, subject only to the ethical principles of the American Medical Association as adopted by the MAG. It supports the principal that any bona fide emergency patient is entitled to adequate emergency medical care regardless of his ability to pay or his creed, sex, race, or national origin. MAG members are urged to continue in their long-established policy of voluntarily providing care to individuals on the basis of medical need, regardless of financial status — with or without remuneration.

It is the continued policy of the MAG that each physician should decide for himself whether he should participate in Medicaid after reviewing the statement of participation and the physician reimbursement policy manual.

MAG Honors High School Students

The MAG has honored three of the state's high school students for their exhibits at this year's Georgia Science and Engineering Fair in Athens. The fair was a complete success, as over 600 visitors attended. There were 550 exhibitors.

Savings bonds were awarded from the MAG to: Jerry Riley, Harper High School, Atlanta, first prize for "The Biochemical Characterization of Induced Mutable Responses of the Lactose Non-fermenting Mutant of *E. coli* by the Enzyme B-galactosidase Caused by High Energy Cosmic Radiation"; Tyrus Daniel, Therrell High School, East Point, second prize for "A Study of Cellulose Acetate Electrophoresis: A Test for Sickle-Cell Anemia"; and Gina Cox, Tiftarea Academy, Tifton, third prize for "Understanding Blood Pressure Monitoring."

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I've told this before . . .

A Perfect Demonstration

ONE SUNDAY MORNING in the early 1930's, along about 9 a.m., I received a long distance phone call at my office from a man who said his name was Sam Moore. He was calling from Bells store near High Falls, Georgia, out a ways from Griffin. He had dislocated his shoulder and wanted to know if I kept office hours on Sunday morning. I said I did. (In fact, in those days I kept office hours at all times of any day.) Sam said he was going to get his friend to drive him in and would be at my office about 11 o'clock.

I was associated at the time with Dr. Zack Cowan. He usually came down on Sunday morning about 10 o'clock to see a few patients who worked the rest of the week. I told him about Sam coming in and asked him if he would stay in case the patient needed an anesthetic. He was glad to oblige.

Sam arrived right at 11 o'clock. He said the accident had happened about 3 hours ago and now any arm motion was extremely painful. He lay down on the table, and Dr. Cowan gave him a few whiffs of chloroform. As soon as he had relaxed, I took off my shoes, put my foot in his axilla, and gently pulled his arm out away from his body. There was a little click as the head of the humerus slipped back into its normal position.

Within a few minutes he was awake and much more comfortable, and we started talking about High Falls. Some of my wife's family had lived there many years ago, and I was quite familiar with the country. Then, I asked him how he had dislocated his shoulder.

"Well, I'll show you," he said, and got down off the examining table. He took a stance and said, "I was standing on this rock, like this, see, fishing and was getting ready to cast, like this." He put his arm back to demonstrate and about that time his foot slipped and his body twisted. We heard a snap. Sam groaned and grabbed his shoulder . . . it had been a perfect demonstration.

J. G. McDaniel, M.D.
Atlanta

(Editor's note: Others wishing to contribute to this page should send their stories to the attention of the Managing Editor of the JMAG.)

Physician's Recognition Award Recipients

LISTED BELOW *are those physicians in Georgia who have earned the AMA's Physician's Recognition Award from March through April 1979.*

The award was established in 1969 "to recognize, encourage and support physicians who participate regularly in continuing medical education and to emphasize the importance of developing more meaningful continuing medical education opportunities for physicians." A minimum of 150 credit hours of CME must be earned over a three-year period to qualify for the award. The hours may include such activities as conferences, residencies, teaching, writing, private reading, listening to cassettes, home study courses, consultation, and peer review; at least 60 of the hours, however, must be from formal CME programs sponsored or co-sponsored by organizations accredited for these activities.

We congratulate the following physicians who have distinguished themselves and their profession by their commitment to continuing education:

Emile Glines Abbott, Conyers
William Carroll Acton, Macon
Alfred Agrin, Gainesville
Earnest C. Atkins, Atlanta
Jose Luis Balbona, Atlanta
William Elliott Barfield, Augusta
Jack Miles Bates, Gainesville
Ronald C. Bloodworth, Smyrna
Jose Castillo Campa, Valdosta
Robert William Crow, Atlanta
Paul Edward Cundey, Augusta
William Simmons Davis, Atlanta
Marion Spencer Dressler, Atlanta
Lawrence Joseph Duane, Waycross
Michaela Dynin, Savannah
William Hugh Earley, Gainesville
Richard Arthur Elmer, Atlanta
Michael B. Feinerman, Austell
Elliott Ronald Finger, Savannah
Ladislav V. Fischmeister, Augusta
Alan Selig Fleischer, Atlanta
Robert E. Fokes, Moultrie
Ronald Allen Freeman, Macon
John White Garland, Gainesville
John Calvin Garrett, Atlanta
Douglas Dennis Glover, Marietta
Stephen Richard Goldman, Atlanta
Rollin Cameron Gordon, Dublin
John Bunyan Griffin, Atlanta
Earl Haltiwanger, Atlanta
John Harold Hartley, Atlanta
Carl Roerig Hartrampf, Atlanta
Lovic Worth Hobby, Atlanta
Stephen Cornelius Hunter, Columbus
Julian Jacobs, Decatur
Louis Jerry Jacobs, Milledgeville
Julian Adolph Jarman, Decatur
James Valiant Kasin, Augusta
Zachary M. Kilpatrick, Augusta
James F. Kirkpatrick, Tifton
Houston Wyke Kitchin, Clayton
George S. Kleris, Atlanta
Dianne Cheryl Leeb, Tucker
John Ransom Lewis, Atlanta
Werner A. Linz, La Grange
Robert Colby Little, Augusta
William Ernest Logan, Martinez
Michael Frederick Lubin, Atlanta
Charles G. Magnan, Macon
Ray Harold McCard, Macon
Richard Earl McCullough, Tifton
James Kenneth McDonald, Augusta
Elfriede M. Mellinger, Augusta
James Kenneth Metcalfe, Atlanta
Charles Aloysius Meyer, Augusta
Karl Stanley Mihalovits, Smyrna
Santosh Kumar Mohanty, Dublin
Robert Theodore Morgan, Sylvester
James Lawton O'Quinn, Augusta
Clyde Lewis Olson, Savannah
Garland D. Perdue, Atlanta
Ramon A. Pineda Azahar, Milledgeville
James W. Purcell, Covington
Clarence Weaver Rawson, Savannah
Ralph Donald Roberts, Fitzgerald
Jonas Robitscher, Atlanta
Michael Roth, Augusta
John Armitage Rusca, Atlanta
William E. Schatten, Atlanta
Robert Charles Silver, Martinez
William Gains Slaughter, Augusta
Morton Slutsky, Atlanta
Jafar Tabatabai, Atlanta
Patrick David Tisdale, Columbus
C. Mark Whitehead, La Grange
Theodore Clark Whitson, Decatur
Robert Gordon Yapp, Augusta
John T. Yauger, Atlanta
George Lionel Zumbro, Augusta

Kennedy Changes NHI Plans

Sen. Edward Kennedy and his Labor allies have formally given up their long and vociferous battle for a federally-financed National Health Insurance (NHI) program, bowing to the exigencies of budget-cutting and inflation.

Instead Kennedy is preparing to offer "a totally new approach" retaining private health insurance and financed largely by the private sector. The as yet unveiled plan is rumored to bristle with stringent federal controls — but is still a long way from the federally-run, federally-financed idea Kennedy launched 10 years ago.

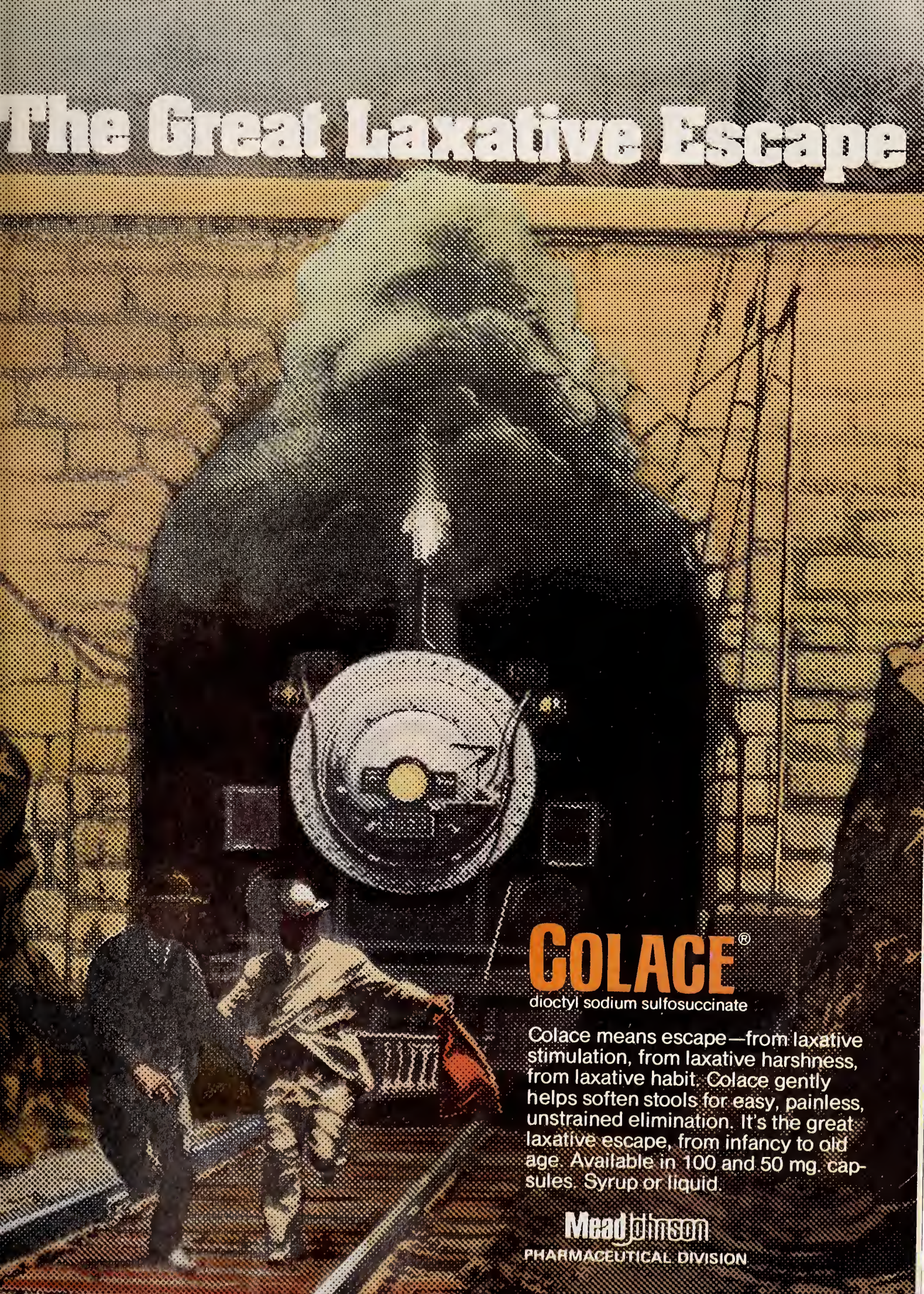
The plan starts with the central concept first advanced by President Nixon of mandating employers to provide comprehensive health care insurance for their workers. A new and very controversial wrinkle is relating premiums to wages with the higher income people subsidizing the premium of lower income workers. Federal premium aid would be provided for poor people and assistance would be given to small companies financially hard hit by the mandate.

The second key idea, left over from the previous Kennedy-Labor plans, calls for a national health spending ceiling and establishment of federal and state budgeting and negotiating mechanisms for setting physicians' fees and regulating hospital costs.

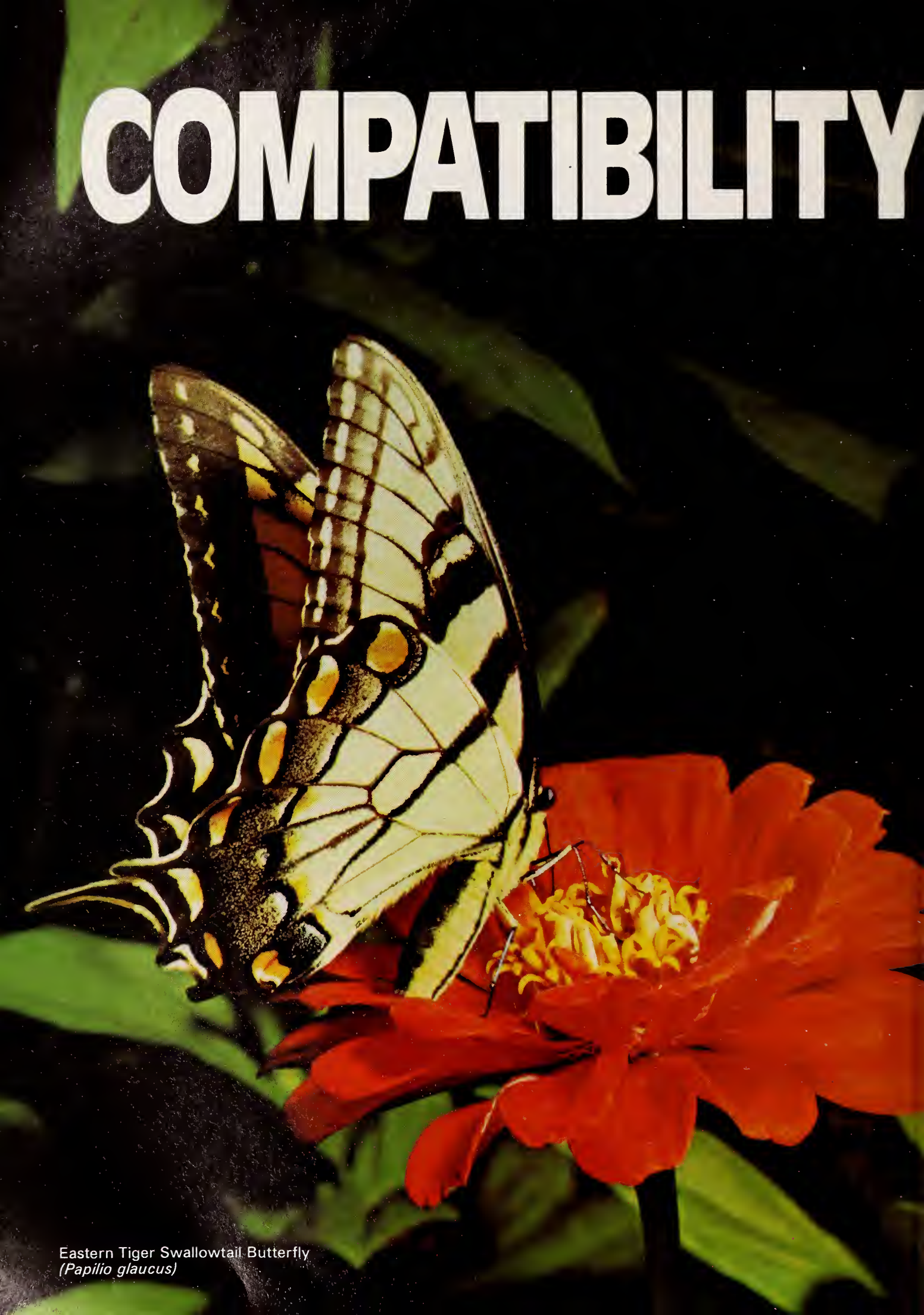
There would be no cost sharing by patients and no limits on hospital or physician care.

All health insurers would be organized into four consortia which would bargain on a state or area-wide basis with health providers on prices.

Although the measure is designed to be approved as one package it could be phased in over a period of years. A likely first phase would be a catastrophic benefit. *(From the Washington Office, American Medical Association.)*


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COMPATIBILITY



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Vasodilan—compatible with coexisting diseases (e.g., glaucoma, diabetes)

Vasodilan has not been reported to affect the course of coexisting disease; it has not been reported to affect blood sugar levels or to raise intraocular pressure.

Vasodilan—compatible with concomitant therapy

Vasodilan has not been reported to affect the treatment of coexisting disease; it is compatible with such drugs as hypoglycemics and miotics.

Vasodilan—compatible with your total regimen for vascular insufficiency

Vasodilan can be a valuable adjunct in planning a total therapeutic program for vascular insufficiency.

***Indications:** Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, the FDA has classified the indications as follows:

Possibly Effective:

1. For the relief of symptoms associated with cerebral vascular insufficiency.
2. In peripheral vascular disease of arteriosclerosis obliterans, thromboangiitis obliterans (Buerger's Disease) and Raynaud's disease.

Final classification of the less-than-effective indications requires further investigation.

Composition: Vasodilan tablets, isoxsuprine HCl, 10 mg. and 20 mg.
Vasodilan injection, isoxsuprine HCl, 5 mg., per ml.

Dosage and Administration: Oral: 10 to 20 mg., three or four times daily.
Intramuscular: 5 to 10 mg. (1 or 2 ml.) two or three times daily. Intramuscular administration may be used initially in severe or acute conditions.

Contraindications and Cautions: There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding.

Parenteral administration is not recommended in the presence of hypotension or tachycardia.

Intravenous administration should not be given because of increased likelihood of side effects.

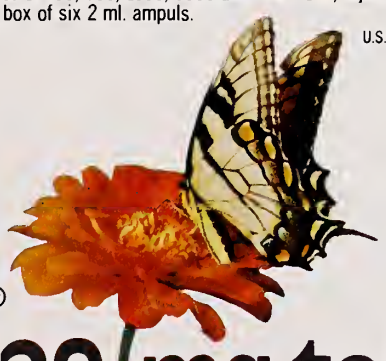
Adverse Reactions: On rare occasions oral administration of the drug has been associated in time with the occurrence of hypotension, tachycardia, nausea, vomiting, dizziness, abdominal distress, and severe rash. If rash appears the drug should be discontinued.

Although available evidence suggests a temporal association of these reactions with isoxsuprine, a causal relationship can be neither confirmed nor refuted.

Administration of single dose of 10 mg. intramuscularly may result in hypotension and tachycardia. These symptoms are more pronounced in higher doses. For these reasons single intramuscular doses exceeding 10 mg. are not recommended. Repeated administration of 5 to 10 mg. intramuscularly at suitable intervals may be employed.

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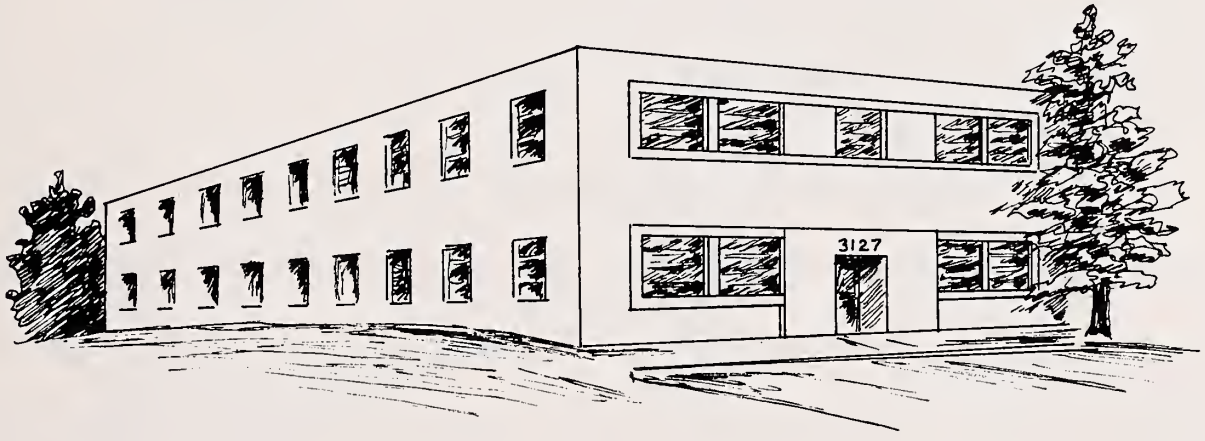
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Reporting Cases of Child Abuse



This logo of the 1979 International Year of the Child, designed by Erik Jerichau to symbolize the message that adults will help children whenever they are in need, has been distorted to bring to your attention that child abuse continues to rear its ugly head.

Physicians are required by law to report suspected child abuse. Yet 1977-78 Georgia statistics show that only about 3% of the reported cases of child abuse were reported by physicians, compared to approximately 30-40% which had been treated by physicians. From July 1, 1977, through June 30, 1978, a total of 2,049 cases of physical abuse were reported in Georgia. It is estimated that if abuse from neglect were reported, these figures would be 3 to 10 times higher. Because of the difficulty in defining neglect, no accurate statistics are available.

If you suspect any cases of child abuse, you must report it to the Child Protective Services at your local Department of Family and Children's Services. You need not report to the police, as this will be done by the department you notify. By law, you are immune from civil or criminal liability in connection with the report you make.

Erratum

In the May issue of the *JMAG*, the following table referred to on page 382 in the article "Toward Solving Teenage Pregnancy in Georgia" by Robert A. Hatcher, M.D., Jacob B. Adams, M.D., and Monica S. Oakley, R.N., was omitted. We sincerely apologize for this error.

TABLE 1. METHOD EFFECTIVENESS: THEORETICAL AND ACTUAL USE RATES
Number of Pregnancies during the First Year of Use per 100 Non-Sterile Women Initiating Method

Method	Used Correctly and Consistently	Average U.S. Experience Among 100 Women Who Wanted No More Children
	Theoretical Effectiveness	Actual Use Effectiveness
Abortion	0	0+
Abstinence	0	?
Hysterectomy	0.0001	0.0001
Tubal Ligation	0.04	0.04
Vasectomy	0.15	0.15+
Oral Contraceptive (combined)	0.34	4[a]-10[b]
I.M. Long-Acting Progestin	0.25	5-10
Condom + Spermicidal Agent	Less than 1[c]	5
Low Dose Oral Progestin	1-1.5	5-10[b]
IUD	1-3	5[a]
Condom	3	10[a]
Diaphragm (with spermicide)	3	17[a]
Spermicidal Foam	3	22[a]
Coitus Interruptus	9	20-25
Rhythm (Calendar)	13	21[a]
Lactation for 12 months	25	40[d]
Chance (sexually active)	90[e]	90[e]
Douche	?	40[a]

[a] Ryder, Norman B., "Contraceptive Failure in the United States," *Family Planning Perspectives* 5:133-142, 1973.

[b] Oral contraceptive failure rates may be far higher than this, if one considers women who become pregnant after discontinuing oral contraceptives, but prior to initiating another method. ORAL CONTRACEPTIVE DISCONTINUATION RATES AS HIGH AS 50-60% in the first year of use are not uncommon in family planning programs.

[c] Data are normally presented as Pearl indices. For conversion to the form used here, the Pearl index was divided by 1300 to give the average monthly failure rate n. The proportion of women who would fail within one year is then $1 - (1 - n)$.

[d] Most women supplement breast feedings, significantly decreasing the contraceptive effectiveness of lactation. In Rwanda 50% of non-lactating women were found to conceive by just over 4 months postpartum. It might be noted that in this community sexual intercourse is culturally permitted from about 5 days postpartum on (Bonte, M., and van Balen, H., *J. BioSoc. Sci.* 1:97, 1969).

[e] This figure is higher in younger couples having intercourse frequently, lower in women over 35 having intercourse infrequently. For example, MacLeod found that within 6 months 94.6% of wives of men under 25 having intercourse four or more times per week conceived. Only 16.0% of wives of men 35 and over having intercourse less than twice a week conceived (MacLeod, *Fertility and Sterility* 4:10-33, 1953).

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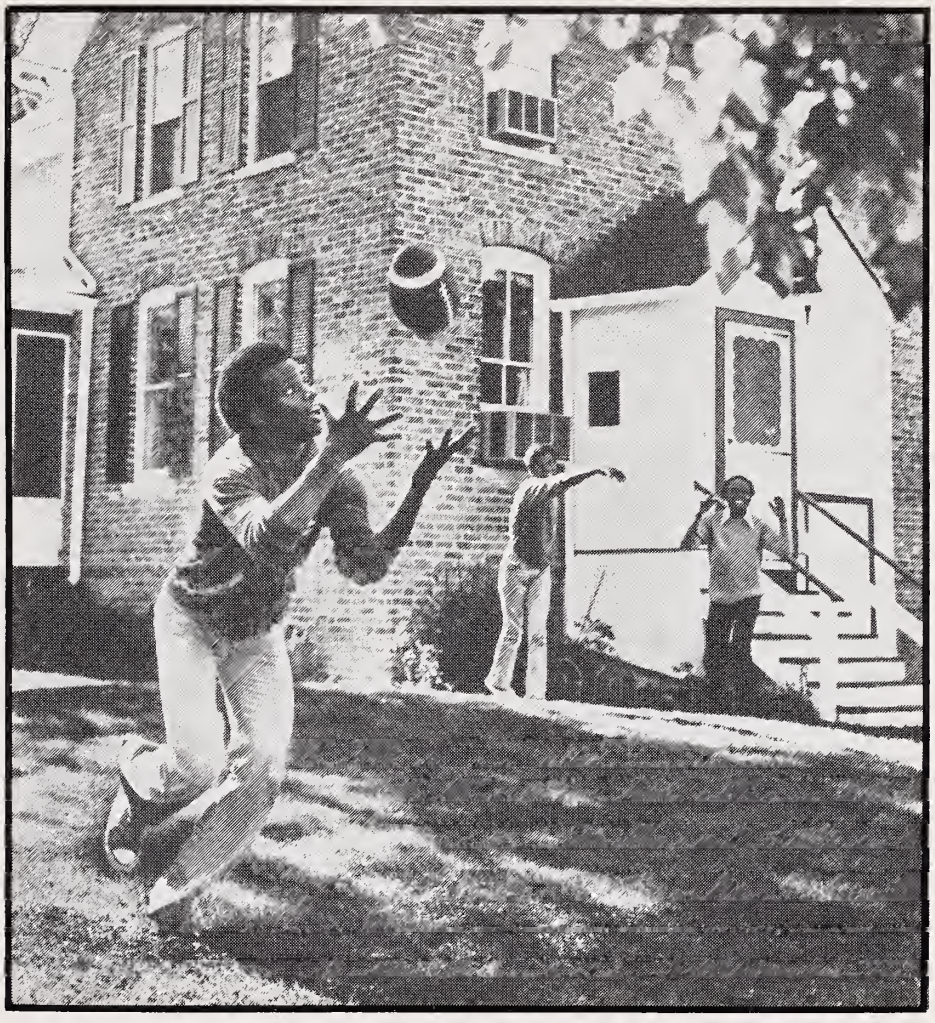
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Jeff raced around the flower bed, past the oak tree and caught it on his fingertips just as he reached the driveway.

A Great Pair of Hands.

I watched my son Tom throw the football in a long, clean spiral to his brother Jeff. Jeff raced around the flower bed, past the oak tree, and caught it on his ngertips just as he reached the driveway. What a pair f hands that kid had. If he tried, he could get a college ootball scholarship easily, I thought. Yes, he had a great air of hands.

His mother had noticed that years ago. When he as just a baby she'd say, "Look at those long, sensitive ngers. He's going to be a great pianist someday." It was ght around that time she insisted I join the Payroll avings Plan and buy some U.S. Savings Bonds for the ids' education.

Well, I never tried to stop him from playing the iano. And his mother never kept him away from football, ven though I'm sure she worried about those sensitive ngers. We let him make up his own mind about what e'd do with his life.

Later that same day, I could hear Jeff playing some omplicated classical piece on the piano. And I knew I'd better dig out those Bonds. They don't give football scholarships at those fancy music schools. And I had to admit that even though he was great at football, he could play the piano even better.

When Jeff left for school his mother said, "Well it'll cost a lot, but it'll be worth it." I nodded in agreement, but I really felt a lot better when young Tom said, "Don't worry, Dad, I'm going to State, and they give out a *lot* of football scholarships."

Then, I remembered. *That* kid had a great arm.

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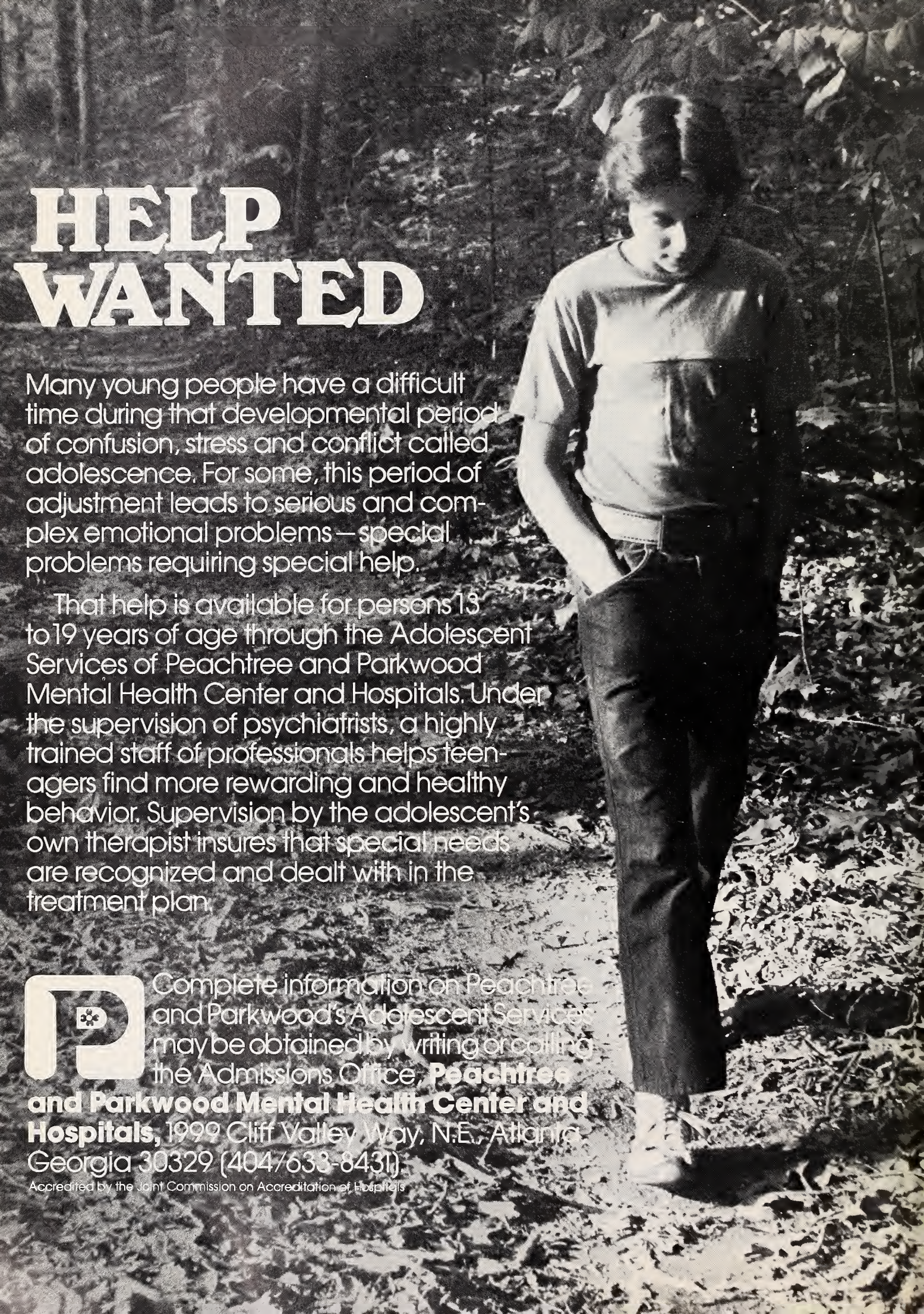
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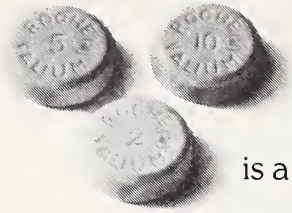
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Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

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The large majority of smokers indicate they would quit if their doctors told them to.

And studies confirm that a large proportion of patients have quit upon advice from their doctors.

However, about two-thirds of smokers report that they've never received advice on quitting from their doctors. It could be their doctors don't want to push them. Or maybe quitting is given a lower priority than other health problems.

But we believe a lot of doctors don't tell their patients to quit smoking for one simple reason: they don't know how to answer the inevitable "how."

The National Cancer Institute has developed a free "Helping Smokers Quit" kit to help you answer the "how" and to help your patients quit the smoking habit. Materials for this kit were pretested with the cooperation of the Harris County (Texas) Medical Society and M.D. Anderson Hospital and Tumor Institute in Houston, Texas.

The National Cancer Institute will provide the "Helping Smokers Quit" kit free of charge to all physicians who want to participate in this important effort. Included in the kit are guidelines for physicians, a self-test to help smoking patients determine why they smoke, pamphlets with tips on quitting, and waiting room posters to introduce the subject. Each kit contains enough materials to help 50 of your smoking patients who want to quit.

Show them how to quit.

Don't delay! To receive the National Cancer Institute's free "Helping Smokers Quit" kit, fill out this order form and return it today.

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Mail to "Helping Smokers Quit" Kit
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JOURNAL
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COVER

The bell on the cover symbolizes the call to action of the 1979 Annual Session of the House of Delegates in Savannah. Cover design by Richard Lyons. Special thanks to Bill Wallis and his Kamera Haus for their cooperation and expertise.

Letters to the Editor . . .

More Support for "Another Look" at Teenage Pregnancy

Dear Sir:

I do not see teenage pregnancy as our problem — rather, it is a result of our problem. If we don't like the outcome, teenage pregnancy, why don't we look at the source — moral decay? Any society that defies both God and nature by trying to separate sexual intercourse from having babies is sick, and it won't get well till it puts sex back into marriage where it belongs. Only in the security of marriage can one appreciate the sanctity of the act and shoulder the responsibility it carries. I feel sorry for teenagers today. How can they be happy and lovable if the good child is the odd one? They are misled by adults, some even in authority, lacking in morals, sometimes pressured into situations they cannot possibly handle. How confusing it must be! We all know most of our troubles stem from lack of self-esteem. Yet how can a teenager involved in sexual activity think well of himself? How can he build a feeling of self-worth in a society bent on its destruction? Do you ever hear the word "restraint" today? Yet, how is character built if not by meeting temptation and resisting it? I thought the editorial "Another Look" was excellent. We need more thinking people like you, concerned over the sadnesses of our times.

Mrs. Ursula Daniel
Minneapolis

Dear Sir:

I would like to speak up in support of the editorial which appeared in last month's [May] *JMAG* concerning teenage pregnancy. This was an extraordinarily perceptive view of statistics, ie: that a "lack of decline in numbers actually is an increase in teenage pregnancies"! I further think it is proper for us to point the finger of blame at ourselves instead of at society. The editorial places the blame squarely on the shoulders of parents and social agencies which are unwilling to take a stand on moral issues.

The philosophy of social programs to "not make value judgements" is an error in my view. In this era of protecting the rights of all groups, I feel we have gone overboard in not asking for higher moral values from our children.

Sincerely,
Harrison L. Rogers Jr., M.D.
Atlanta

Dear Sir:

Congratulations on an excellent issue devoted to teenage pregnancy. I offer the following hopefully constructive criticism: Although the occasional statement is made that the problem cuts across social and racial boundaries, no statistics other than differences between perinatal mortality for black vs. white teenagers are given. Most physicians, I believe, would say "Yes, the problem exists, but it exists for the poor, the black, the uneducated, or those who live in the inner city. It couldn't occur in my upper-middle class, college-educated, upwardly mobile white suburban practice."

Perhaps these statistics are impossible to obtain. The numbers of abortions, out-of-wedlock teenage pregnancies, babies placed for adoption, or teenagers treated for venereal diseases hints at the answer, but may reflect only those unfortunate enough to become infected and/or pregnant. A higher black than white incidence might only indicate that some whites are clever enough to escape detection, and reinforce the notion that upper-middle class suburbanites are relatively free of risk, while contributing to racial prejudice.

I'm not sure, but I believe that the counties having the highest incidence of venereal diseases, abortions, teenage pregnancies, etc. are those with the highest percentages of black population. I also know that in my own predominantly white practice an astonishing number of the mothers have had not one but two or more pre-marital abortions.

May I hasten to add this is not meant to antagonize or offend anyone, but it is precisely the notion "this sort of thing doesn't happen in *my* practice" that must be dispelled before you can expect most private practitioners to give anything more than lip service to this problem.

Sincerely,
E. Noel Preston, M.D.
Atlanta

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MEDICAL MEETING CALENDAR

JULY

13-15 — *Kissimmee, FL;* **CORONARY DISEASE, EXERCISE TESTING AND CARDIAC REHABILITATION;** Contact: International Medical Education Corp., 64 Inverness Dr. East, Englewood, CO 80110.

15-18 — *Lexington, KY;* **THE PROCESS OF HEALTH SCIENCE EDUCATION: PAST, PRESENT, AND FUTURE;** Contact: Norm Tucker, Health Education Media Assoc., P.O. Box 771, Riverdale, GA 30274. PH: 404/997-0449.

16-20 — *Jekyll Island;* **TAXES AND INVESTMENTS;** Category 1 credit; Contact: Division of Continuing Education, Medical College of Georgia, Augusta 30912. PH: 404/828-3967.

17 — *Atlanta;* **SEMINAR ON HOSPICE;** Contact: Diane Cowgill, Hospice Atlanta, P.O. Box 8376, Atlanta 30306.

17-18 — *Atlanta;* **MEDICAL OFFICE MANAGEMENT INSTITUTE;** Contact: Conomikes Associates, Inc., 4270 Promenade Way, Ste. 122, Marina del Rey, CA 90291. PH: 800/421-6512.

22-27 — *Durham, NC;* **SUMMER INSTITUTE OF ALCOHOL STUDIES;** Contact: Fritz Anlyan, 06B West Duke Bldg., Duke University, Durham, NC 27708.

25-29 — *Hilton Head Island, SC;* **CONTEMPORARY CLINICAL NEUROLOGY;** Category 1 credit; Contact: Vanderbilt Continuing Education, 305 Medical Arts Bldg., Nashville, TN 37212. PH: 615/322-2716.

30-31 — *Jacksonville, FL;* **LAPAROSCOPY COURSE;** Contact: Robert J. Thompson, M.D., 655 W.8th St., Jacksonville, FL 32209.

AUGUST

2-3 — *Atlanta;* **COPING WITH THE PSYCHOLOGICAL ASPECTS OF DISEASE AND DISABILITY;** Category 1 credit; Contact: Associate Dean for CME, Emory University School of Medicine, 69 Butler St., S.E., Atlanta 30303. PH: 404/588-3534.

2-6 — *Orlando, FL;* **DIAGNOSTIC IMAGING OF THE HEART;** Category 1 credit; Contact: Lawrence R. Muroff, M.D., Educational Symposia, P.O. Box 17241, Tampa, FL 33682.

6-8 — *Kiawah Island, SC;* **PEDIATRIC UPDATE 1979;** Category 1 credit; Contact: Division of Continuing Education, Medical College of Georgia, Augusta 30912. PH: 404/828-3967.

14 — *Knoxville, TN;* **NEW DEVELOPMENTS IN FAMILY PRACTICE, PSYCHIATRY, EMERGENCY MEDICINE, UROLOGY;** Category 1 credit; Contact: Knoxville Academy of Medicine, 422 W. Cumberland Ave., Knoxville, TN 37902.

17-19 — *Kissimmee, FL;* **CLINICAL ECG ARRHYTHMIA MANAGEMENT;** Contact: International Medical Education Corp., 64 Inverness Dr. East, Englewood, CO 80110.

24-26 — *Hilton Head Island, SC;* **CARDIAC SYMPTOMS AND ARRHYTHMIAS;** Contact: International Medical Education Corp., 64 Inverness Dr. East, Englewood, CO 80110.

27-31 — *Nashville, TN;* **TEMPORAL BONE SURGICAL DISSECTION;** Category 1 credit; Contact: Education Auditory Research Foundation, 2000 Church St., Nashville, TN 37236.

11-12 — *Chattanooga, TN;* **TENNESSEE VALLEY MEDICAL ASSEMBLY;** Contact: Chattanooga/Hamilton County Medical Society, 960 E. Third St., Chattanooga, TN 37403.

14-16 — *Hilton Head Island, SC;* **ANNUAL MEETING, GEORGIA GASTROENTEROLOGIC SOCIETY;** Contact: Harold Asher, M.D., 340 Boulevard, N.E., Atlanta 30312.

15 — *Hilton Head Island, SC;* **ANNUAL MEETING, GEORGIA SOCIETY FOR GASTROINTESTINAL ENDOSCOPY;** Contact: Benjamin F. Pike, M.D., 2300 Manchester Expwy., Columbus 31904.

19-21 — *Atlanta;* **33RD ANNUAL MEETING, AMERICAN ELECTROENCEPHALOGRAPHIC SOCIETY;** Contact: Margaret H. Henry, 38238 Glenn Ave., Willoughby, OH 44094. PH: 212/942-9267.

20-22 — *Sea Island;* **ANNUAL MEETING, GEORGIA SURGICAL SOCIETY;** Contact: W. Cecil McGarity, M.D., 1365 Clifton Rd., N.E., Atlanta 30322.

23-27 — *Orlando;* **MEETING, CIVIL AVIATION MEDICAL ASSOCIATION;** Contact: A. Carriere, 801 Green Bay Rd., Lake Bluff, IL 60044.

27-29 — *Knoxville, TN;* **ARTHRITIS SYMPOSIUM;** Contact: Dennis K. Wentz, M.D., UT Center for the Health Sciences, 62 S. Dunlap St., Memphis, TN 38163. PH: 901/528-5606.

28-30 — *Pine Mountain;* **31ST ANNUAL MEETING, GEORGIA HEART ASSOCIATION;** Contact: Georgia Heart Assoc., 2581 Piedmont Rd., N.E., Atlanta 30324.

OCTOBER

8-11 — *Atlanta;* **ANNUAL MEETING, AMERICAN ACADEMY OF FAMILY PHYSICIANS;** Contact: R. Tusken, 1740 W. 92nd St., Kansas City, MO 64114.

20-21 — *Atlanta;* **MAGNET CONFERENCE;** Catetory 1 credit; Contact: Ken Williams, MAG, 938 Peachtree St., N.E., Atlanta 30309. PH: 404/876-7535.

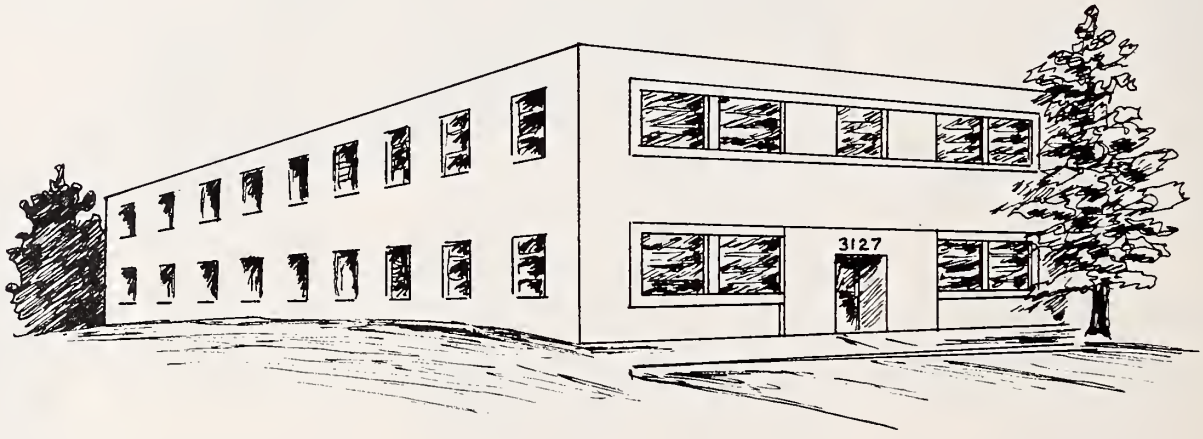
27-28 — *Pine Mountain;* **PHYSICIAN PLACEMENT SEMINAR;** Contact: Joyce Butler, MAG, 938 Peachtree St., N.E., Atlanta 30309. PH: 404/876-7535.

NOVEMBER

15-18 — *Atlanta;* **MAG SCIENTIFIC ASSEMBLY;** Category 1 credit; Contact: Sue McAvoy, MAG, 938 Peachtree St., N.E., Atlanta 30309. PH: 404/876-7535.

For additional information on these and other meetings, contact MAG, Division of Education 404/876-7535.

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"The House That Love Built"

It has often been said "there is no place like home." This statement holds painful truth for a group of Georgia families who must frequently leave their homes and travel to Atlanta's Henrietta Egleston's Hospital for Children so that their children may receive specialized treatment for leukemia and other cancers. Until recently, parents who could not afford motel costs resorted to sleeping in their child's hospital room, the hospital lobby, and sometimes even in their cars. The emotional and financial burden placed on these families prompted the Atlanta area McDonald's to investigate the situation and determine any need for a Ronald McDonald House in Atlanta.

The need for a house in Atlanta was determined early in 1977 when Dr. Abdel Ragab, Director of Emory Hospital Pediatric Hematology and Oncology Division, made a report to the Greater Atlanta McDonald's Operators Association.

After receiving his report, the Operators pledged to raise $100,000 to purchase a Ronald McDonald House for the families. A kick off press conference was held in July and everyone supporting the project came together — McDonald's operators, doctors, and the parent's group (Children's Oncology Services) spearheading the project. McDonald's began raising their pledge with a "Go Bananas" shake promotion, while Children's Oncology Services began a statewide series of speaking engagements. For one week in July, 100% of the sales from McDonald's banana-flavored shakes was donated to the Ronald McDonald House. The total amount raised from the Banana Shake promotion was $42,000.

Thus, the Atlanta Ronald McDonald House was purchased, a beautiful 2-story home within walking distance of Atlanta's Emory Hospital and Egleston's Hospital for Children. The house has nine bedrooms completely furnished by generous contributors. A sunny playroom and kitchen open on to a large backyard and playground surrounded by trees and azaleas.

According to Children's Oncology Services, "Atlanta Ronald McDonald House is indeed the house that love built. A generous Georgia community opened their hearts to the project and supported efforts locally and statewide. This volunteer spirit is strong and the future of the house depends on continued generous contributions and support."

Tax-free donations to the Ronald McDonald House may be mailed to: Ronald McDonald House, Post Office Box 76853, Atlanta, GA 30328.

Children Experience "Alice in Wonderland" Syndrome

Children who suffer from recurrent headaches or whose families have a history of migraine headaches may experience sudden attacks of impairment of time sense, distortions of body image, and visual hallucinations, known as the "Alice in Wonderland" syndrome, according to Dr. Gerald S. Golden from the University of Texas Medical Branch of Galveston, Texas. Dr. Golden's report appeared in a recent issue of *Pediatrics*.

The complex set of symptoms was given its name by Dr. C. W. Lippman in 1952, when a patient stated that she spontaneously felt short and wide as she walked along, referring to it as a "Tweedle Dum or Tweedle Dee feeling." He cited case reports of two children who reported feeling "like things were going too fast, and my hands were made out of tiny twigs with a little mushy flesh on the outside"; and "my body was becoming too large, and it appeared as if a human hand was covering my field of vision."

One 11-year-old girl said that she was "sitting on a bench in a swampy area talking, when all of a sudden something popped out from inside the seat. A body came out, hanging upside down — all bloody — and then went back in."

In each case, the child was conscious and alert during the episode, and there was no evidence of psychiatric illness, drug ingestion, or seizures. Both children had a personal history of headaches, one of them suffering from migraines, and a strong family history of migraines.

Dr. Golden noted that the symptoms may appear several days before a headache, just before the onset of a headache, or, in some cases, with no headache occurring.

"The pathophysiology of the condition has not been fully determined," said Dr. Golden, "but the timing of the symptoms and their occurrence without headaches suggest that the vasoconstrictive phase of the migraine phenomenon is involved." This syndrome has also been reported in adults. Diagnosis of the syndrome is important, since it can be mistaken for psychotic or drug-induced hallucinations, encephalitic illness, or psychomotor seizures.

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CHILDREN'S PROGRAM: A comprehensive program with a structured milieu approach involving children and their parents. Daily group sessions, individualized school instruction, family therapy along with music, art, horticulture, recreational and occupational therapies comprise each child's day.

ADOLESCENT PROGRAM: An intense and highly structured milieu approach, designed to encourage the adolescent's active participation and to promote emotional growth. Among therapies included are daily community meetings, identity groups, individualized school instruction, family therapy, recreational, occupational and music therapy.

ADDICTIVE DISEASE PROGRAM: Alcoholism and drug addiction are considered diseases of the total person in the addictive disease unit of Peachford. Because the disease affects the physical, mental and emotional well-being of the patient, physical detoxification is considered to be only the beginning of the rehabilitation program.
Patients are completely drug free prior to discharge.
Twenty-four hour admittance is offered for all programs.





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CHARLES D. STEWART, JR., M.D.
Director, Adolescent Unit

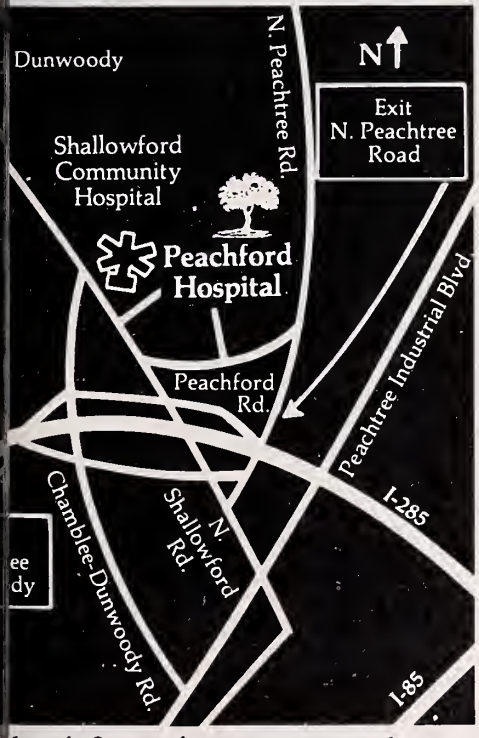
JOHN B. HARDMAN, M.D.
Director, Children's Unit

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The hospital has an open medical staff including psychiatrists, other medical specialists and allied professionals. Separate committees supervise the children's program, adolescent program, adult psychiatric program and the alcohol and drug abuse unit.

The professional staff consists of nurses, social workers, recreational therapists, occupational therapists, an art therapist, a music therapist, dance therapist, teachers and counselors.



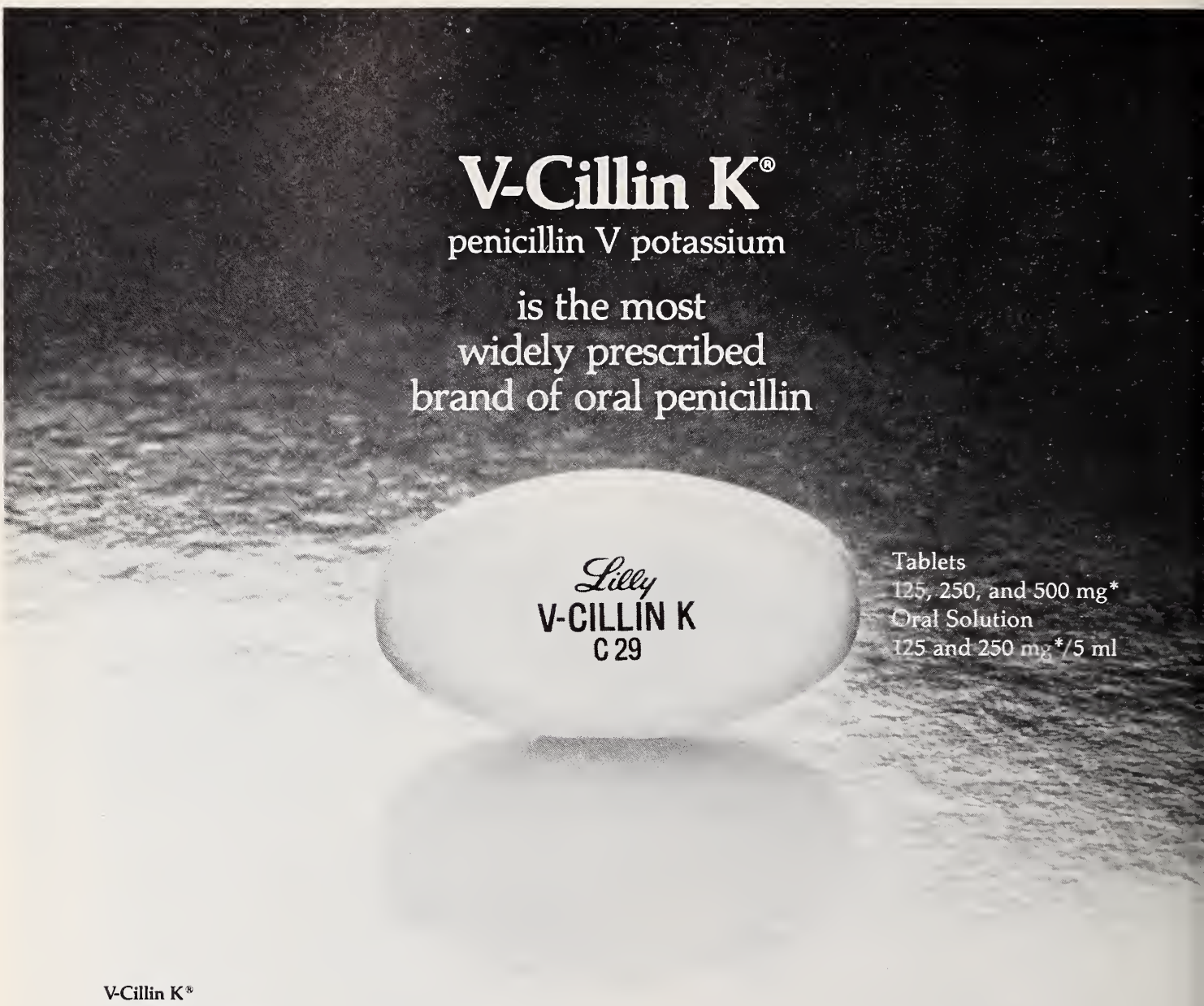
PHYSICAL FACILITIES:
Located on 37 acres of rolling, wooded land just north of I-285 in DeKalb County, the hospital is near the Shallowford Community Hospital which provides medical support for Peachford Hospital. Peachford is equipped with an X-ray department, a laboratory, emergency treatment room, auditorium/gymnasium, adolescent and children's schools, group therapy rooms, occupational therapy shop, year-round swimming pool and athletic fields for volley ball, tennis, basketball, and badminton.

Peachford Hospital is owned by Charter Medical Corporation, Macon, Georgia. Each service is fully accredited by the Joint Commission on the Accreditation of Hospitals.

lete information or a personal tour of the facilities and explanation of programs, contact:

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Indications: For the treatment of mild to moderately severe pneumococcal respiratory tract infections and mild staphylococcal skin and soft-tissue infections that are sensitive to penicillin G. See the package literature for other indications.

Contraindication: Previous hypersensitivity to penicillin.

Warnings: Serious, occasionally fatal, anaphylactoid reactions have been reported. Some patients with penicillin hypersensitivity have had severe reactions to a cephalosporin; inquire about penicillin, cephalosporin, or other allergies before treatment. If an allergic reaction occurs, discontinue the drug and treat with the usual agents (e.g., epinephrine or other pressor amines, antihistamines, or corticosteroids).

Precautions: Use with caution in individuals with histories of significant allergies and/or asthma. Do not rely on oral administration in patients with severe illness, nausea, vomiting, gastric dilatation, cardiospasm, or intestinal hypermotility. Occasional patients will not absorb therapeutic amounts given orally. In streptococcal infections, treat until the organism is eliminated (minimum of ten days). With prolonged use, nonsusceptible organisms, including fungi, may overgrow; treat superinfection appropriately.

Adverse Reactions: Hypersensitivity, including fatal anaphylaxis. Nausea, vomiting, epigastric distress, diarrhea, and black, hairy tongue. Skin eruptions, urticaria, reactions resembling serum sickness (including chills, edema, arthralgia, prostration), laryngeal edema, fever, and eosinophilia. Infrequent hemolytic anemia, leukopenia, thrombocytopenia, neuropathy, and nephropathy, usually with high doses of parenteral penicillin. [102175]

***Equivalent to penicillin V.**

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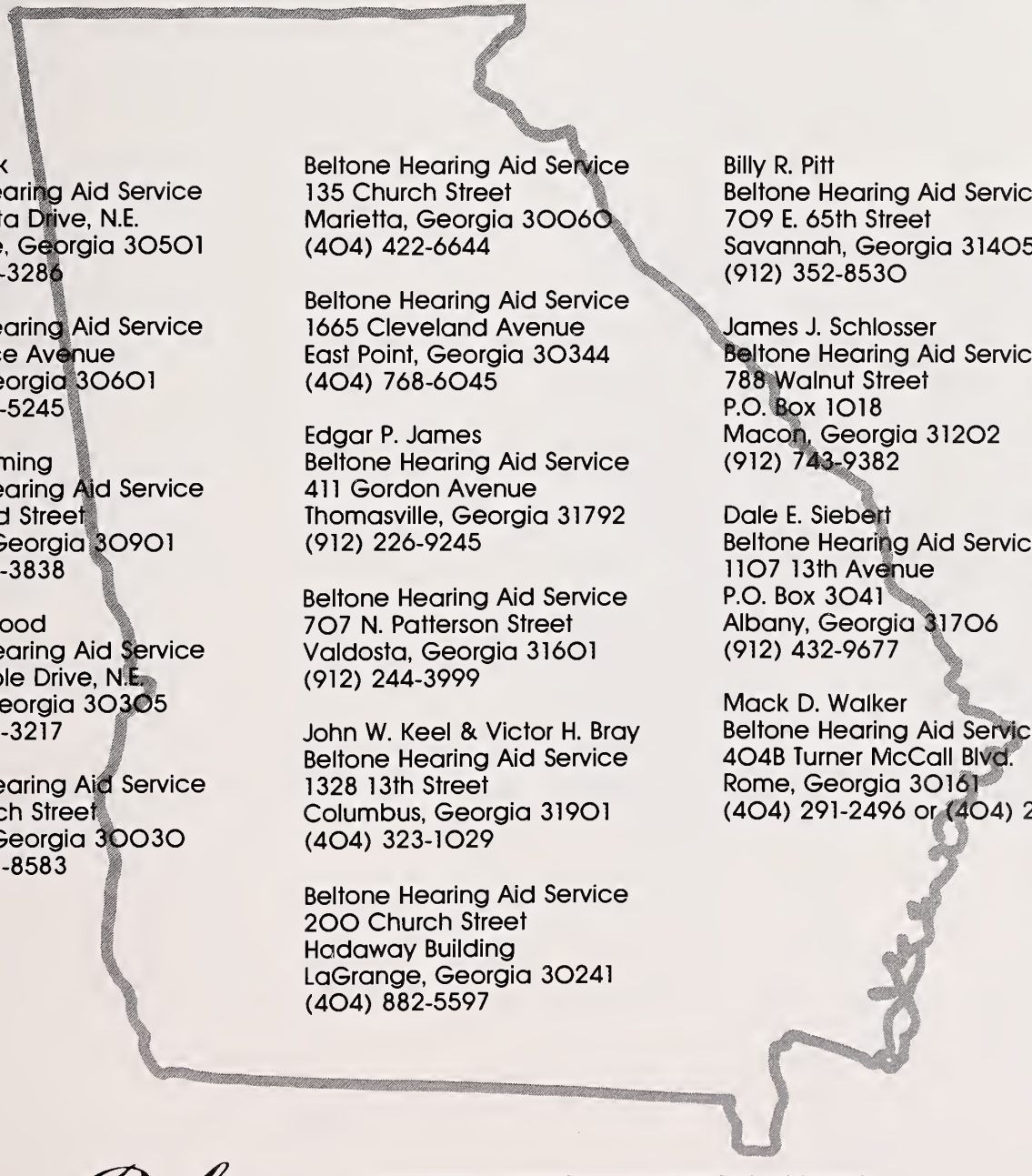
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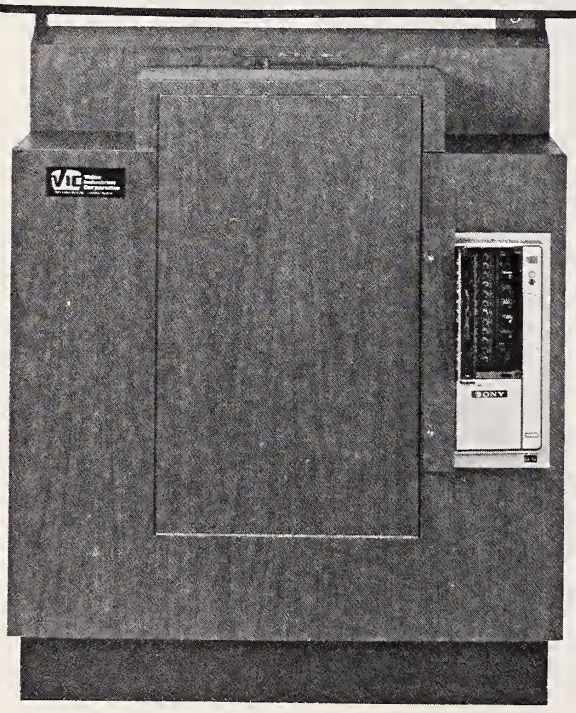
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Tenuate Dospan®
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AVAILABLE ONLY ON PRESCRIPTION
Brief Summary
INDICATION: Tenuate and Tenuate Dospan are indicated in the management of exogenous obesity as a short-term adjunct (a few weeks) in a regimen of weight reduction based on caloric restriction. The limited usefulness of agents of this class should be measured against possible risk factors inherent in their use such as those described below.
CONTRAINDICATIONS: Advanced arteriosclerosis, hyperthyroidism, known hypersensitivity, or idiosyncrasy to the sympathomimetic amines, glaucoma. Agitated states. Patients with a history of drug abuse. During or within 14 days following the administration of monoamine oxidase inhibitors, (hypertensive crises may result).
WARNINGS: If tolerance develops, the recommended dose should not be exceeded in an attempt to increase the effect; rather, the drug should be discontinued. Tenuate may impair the ability of the patient to engage in potentially hazardous activities such as operating machinery or driving a motor vehicle; the patient should therefore be cautioned accordingly. *Drug Dependence*: Tenuate has some chemical and pharmacologic similarities to the amphetamines and other related stimulant drugs that have been extensively abused. There have been reports of subjects becoming psychologically dependent on diethylpropion. The possibility of abuse should be kept in mind when evaluating the desirability of including a drug as part of a weight reduction program. Abuse of amphetamines and related drugs may be associated with varying degrees of psychologic dependence and social dysfunction which, in the case of certain drugs, may be severe. There are reports of patients who have increased the dosage to many times that recommended. Abrupt cessation following prolonged high dosage administration results in extreme fatigue and mental depression; changes are also noted on the sleep EEG. Manifestations of chronic intoxication with anorectic drugs include severe dermatoses, marked insomnia, irritability, hyperactivity, and personality changes. The most severe manifestation of chronic intoxications is psychosis, often clinically indistinguishable from schizophrenia. *Use in Pregnancy*: Although rat and human reproductive studies have not indicated adverse effects, the use of Tenuate by women who are pregnant or may become pregnant requires that the potential benefits be weighed against the potential risks. *Use in Children*: Tenuate is not recommended for use in children under 12 years of age.
PRECAUTIONS: Caution is to be exercised in prescribing Tenuate for patients with hypertension or with symptomatic cardiovascular disease, including arrhythmias. Tenuate should not be administered to patients with severe hypertension. Insulin requirements in diabetes mellitus may be altered in association with the use of Tenuate and the concomitant dietary regimen. Tenuate may decrease the hypotensive effect of guanethidine. The least amount feasible should be prescribed or dispensed at one time in order to minimize the possibility of overdosage. Reports suggest that Tenuate may increase convulsions in some epileptics. Therefore, epileptics receiving Tenuate should be carefully monitored. Titration of dose or discontinuance of Tenuate may be necessary.
ADVERSE REACTIONS: *Cardiovascular*: Palpitation, tachycardia, elevation of blood pressure, precordial pain, arrhythmia. One published report described T-wave changes in the ECG of a healthy young male after ingestion of diethylpropion hydrochloride. *Central Nervous System*: Overstimulation, nervousness, restlessness, dizziness, jitteriness, insomnia, anxiety, euphoria, depression, dysphoria, tremor, dyskinesia, mydriasis, drowsiness, malaise, headache; rarely psychotic episodes at recommended doses. In a few epileptics an increase in convulsive episodes has been reported. *Gastrointestinal*: Dryness of the mouth, unpleasant taste, nausea, vomiting, abdominal discomfort, diarrhea, constipation, other gastrointestinal disturbances. *Allergic*: Urticaria, rash, ecchymosis, erythema. *Endocrine*: Impotence, changes in libido, gynecomastia, menstrual upset. *Hematopoietic System*: Bone marrow depression, agranulocytosis, leukopenia. *Miscellaneous*: A variety of miscellaneous adverse reactions has been reported by physicians. These include complaints such as dyspnea, hair loss, muscle pain, dysuria, increased sweating, and polyuria.
DOSAGE AND ADMINISTRATION: Tenuate (diethylpropion hydrochloride): One 25 mg. tablet three times daily, one hour before meals, and in midevening if desired to overcome night hunger. Tenuate Dospan (diethylpropion hydrochloride) controlled-release: One 75 mg. tablet daily, swallowed whole, in midmorning. Tenuate is not recommended for use in children under 12 years of age.
OVERDOSAGE: Manifestations of acute overdosage include restlessness, tremor, hyperreflexia, rapid respiration, confusion, assaultiveness, hallucinations, panic states. Fatigue and depression usually follow the central stimulation. Cardiovascular effects include arrhythmias, hypertension or hypotension and circulatory collapse. Gastrointestinal symptoms include nausea, vomiting, diarrhea, and abdominal cramps. Overdose of pharmacologically similar compounds has resulted in fatal poisoning, usually terminating in convulsions and coma. Management of acute Tenuate intoxication is largely symptomatic and includes lavage and sedation with a barbiturate. Experience with hemodialysis or peritoneal dialysis is inadequate to permit recommendation in this regard. Intravenous phentolamine (Regitine®) has been suggested on pharmacologic grounds for possible acute, severe hypertension, if this complicates Tenuate overdosage.

Product Information as of April, 1976

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MERRELL-NATIONAL LABORATORIES
Division of Richardson-Merrell Inc.
Cincinnati, Ohio 45215, U.S.A.

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References: 1. Citations available on request—Medical Research Department, MERRELL RESEARCH CENTER, MERRELL-NATIONAL LABORATORIES, Cincinnati, Ohio 45215. 2. Hoekenga, M.T., O'Dillon, R.H., and Leyland, H.M.: A Comprehensive Review of Diethylpropion Hydrochloride. International Symposium on Central Mechanisms of Anorectic Drugs, Florence, Italy, Jan. 20-21, 1977.

Merrell

8-3921 (Y587A)

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(diethylpropion hydrochloride NF)
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A useful short-term adjunct in an indicated weight loss program.

Overweight patients in certain diagnostic categories often require strict appetite control and a successful program of weight reduction may tend to diminish the incidence or severity of the complications in some patients. Diethylpropion hydrochloride has been reported useful in such patients and while it is not suggested that Tenuate itself in any way reduces the complications of overweight, it may have a useful place as a short-term adjunct in a prescribed dietary regimen. **Tenuate should not be administered to patients with severe hypertension; see additional Warnings and Precautions on the opposite page.**

In uncomplicated overweight.

Many patients, on the other hand, present with excess fat but no disease. While this condition is often termed uncomplicated obesity, complications of both a social and a psychologic nature may be distressingly real for the patients. In these cases, a short-term regimen of Tenuate can help reinforce your dietary counsel during the important early weeks of an indicated weight loss program.

Clinical effectiveness.

The anorectic effectiveness of diethylpropion hydrochloride is well documented. No less than 16 separate double-blind, placebo-controlled studies attest to its usefulness in daily practice.[1] And the unique chemistry of Tenuate provides "...anorectic potency with minimal overt central nervous system or cardiovascular stimulation."[2] Compared with the amphetamines, diethylpropion has minimal potential for abuse.

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*Studies have shown that obesity is associated with an increased incidence of hypertension, symptomatic heart disease, adult-onset diabetes, and other diseases.

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For prescribing information see opposite page.

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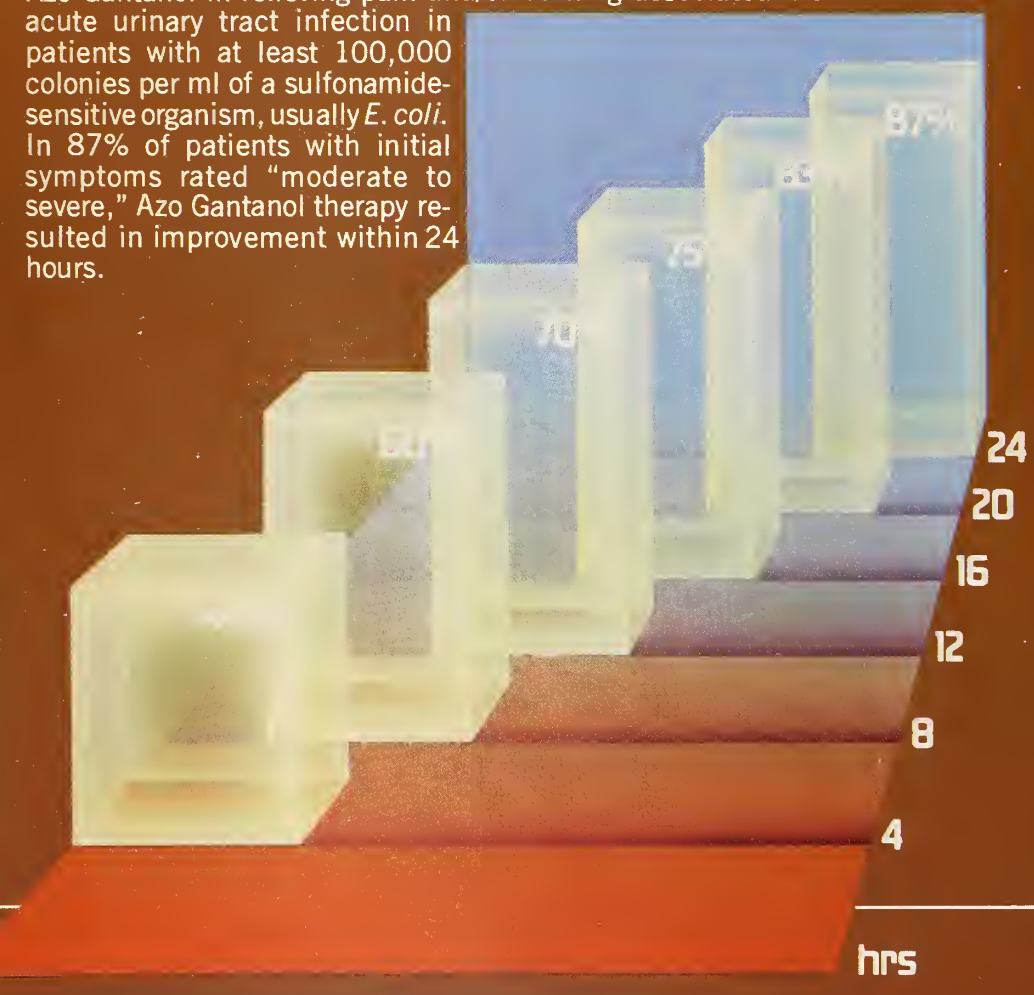
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A controlled, multicenter study assessed the efficacy of Azo Gantanol in relieving pain and/or burning associated with acute urinary tract infection in patients with at least 100,000 colonies per ml of a sulfonamide-sensitive organism, usually *E. coli*. In 87% of patients with initial symptoms rated "moderate to severe," Azo Gantanol therapy resulted in improvement within 24 hours.



Before prescribing, please consult complete product information, a summary of which follows:

Indications: In adults, urinary tract infections complicated by pain (primarily pyelonephritis, pyelitis and cystitis) due to susceptible organisms (usually *E. coli, Klebsiella-Aerobacter, Staphylococcus aureus, Proteus mirabilis,* and, less frequently, *Proteus vulgaris*) in the absence of obstructive uropathy or foreign bodies. **Note: Carefully coordinate *in vitro* sulfonamide sensitivity tests with bacteriologic and clinical response; add aminobenzoic acid to follow-up culture media. The increasing frequency of resistant organisms limits the usefulness of antibacterials including sulfonamides.** Measure sulfonamide blood levels as variations may occur; 20 mg/100 ml should be maximum total level.

Contraindications: Children below age 12; sulfonamide hypersensitivity; pregnancy at term and during nursing period; because Azo Gantanol contains phenazopyridine hydrochloride it is contraindicated in glomerulonephritis, severe hepatitis, uremia, and pyelonephritis of pregnancy with G.I. disturbances.

Warnings: Safety during pregnancy not established. Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been reported and early clinical signs (sore throat, fever, pallor, purpura or jaundice) may indicate serious blood disorders. Frequent CBC and urinalysis with microscopic examination are recommended during sulfonamide therapy.

Precautions: Use cautiously in patients with impaired renal or hepatic function, severe allergy, bronchial asthma; in glucose-6-phosphate dehydrogenase-deficient individuals in whom dose-related hemolysis may occur. Maintain adequate fluid intake to prevent crystalluria and stone formation.

Adverse Reactions: *Blood dyscrasias* (agranulocytosis, aplastic anemia, thrombocytopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia); *allergic reactions* (erythema multiforme, skin eruptions, Stevens-Johnson syndrome, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis); *G.I. reactions* (nausea, emesis, abdominal pains, hepatitis, diarrhea, anorexia, pancreatitis and stomatitis); *CNS reactions* (headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo and insomnia); *miscellaneous reactions* (drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L. E. phenomenon). Due to certain chemical similarities with some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia. Cross-sensitivity with these agents may exist.

Dosage: Azo Gantanol is intended for the acute, painful phase of urinary tract infections. *Usual adult dosage:* 2 Gm (4 tabs) initially, then 1 Gm (2 tabs) B.I.D. for up to 3 days. If pain persists, causes other than infection should be sought. After relief of pain has been obtained, continued treatment with Gantanol (sulfamethoxazole) may be considered.

NOTE: Patients should be told that the orange-red dye (phenazopyridine HCl) will color the urine.

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The combined drag of two bodies which are in close proximity is often higher than the sum drag of the individual parts: this "extra drag" is called interference drag. Mooney paid close attention to designing fairings for the flap hinges, horizontal stabilizers, and other areas to reduce this drag.

Mooney's long wingspan provides good rate-of-climb. A shorter span, like the Bonanza's, would add 4-5 mph to the cruise speed, but would require more power for an acceptable rate of climb.

Skin friction drag is a function of square feet of airplane surface exposed to airflow. There's virtually no "fat" in a 201's surface area, hence, minimum skin friction drag.



Air flowing inside the engine cowling creates a large portion of total airplane drag. Mooney's system of internal aerodynamics uses less air more efficiently and provides even cooling to each cylinder.

There are no unnecessary protuberances in the 201. For instance, a low drag electric OAT is used instead of the traditional "meat thermometer" guage sticking through the windshield. The landing gear leg and brake lines are covered with an inboard gear door. The forward half of the wing on both upper and lower surfaces are flush riveted. Inspection panels on the lower surface are flush mounted.

Leakage drag is caused by air flowing to areas where you don't want it to go. For example, high air pressure from the bottom of the wing "leaking" through flap or aileron gaps to the lower pressure top of the wing results in some drag from the leakage flow itself. In addition, the leakage flow exits the leakage path and disturbs the primary flow causing more drag. Gap seals on flaps and control surfaces reduce the 201's leakage drag and provide for better control as well.

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of the medical association of
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Highlights of the 1979 Annual Session

THE 1979 ANNUAL SESSION of the Medical Association of Georgia (MAG) was hcld in Savannah, Georgia, at the DeSoto Hilton Hotel, April 20-22, 1979. There were 429 persons in attendance, including delegates, alternates, members, Auxiliary, and guests. Forty-eight county medical societies were represented at this Session.

The Annual Banquet was held Saturday evening, April 21. Addresses were given by Tom E. Nesbitt, M.D., President of the American Medical Association, and Carson B. Burgstiner, M.D., President of the MAG.

Highlights of the 1979 House of Delegates are presented here; a detailed report of the Proceedings follows.

Awards

The 1979 Family Physician of the Year Award was presented to C. Emory Bohler, of Brooklet.

Edgar Woody Jr., Atlanta, received a Special Service award for his 25 years of dedicated service to the MAG as editor of the *Journal of the MAG*.

For his contributions to the general public through his participation in civic affairs, Howard C. Derrick Jr. of LaFayette received this year's Civic Endeavor Award.

The recipient of the Distinguished Service Award was Charles L. Hillis of LaFayette.

Nursing

In its report, the MAG Committee on Nursing discussed the extended role of the nurse. This report generated extensive discussion in the reference committee hearing. The House approved the following recommendations of the reference committee: 1) "That the MAG adopt as policy the statement, 'The Medical As-

sociation of Georgia deplores inappropriate use of nursing personnel outside the direct supervision of the physician in government settings, in which the nurses are reported to be functioning as independent medical practitioners.'" and 2) the MAG Committee on Nursing is urged to continue with its intended function of monitoring progress of the concept of the nurse in the extended role and also enhance the concept and encourage the quality of nursing training in the traditional role.

Physician's Assistants

Extended debate took place in the reference committee in its consideration of the report of the MAG Committee on Physician's Assistants (PAs). The House approved the Executive Committee's appointment of a special delegation to urge the officials involved to consider terminating the training and certification of PAs in Georgia as the current training cycles end, unless the need for more PAs is documented. Also approved was a request that the PA Committee continue its efforts in developing guidelines which may, with the Executive Committee's approval, assist the Composite State Board of Medical Examiners in its task of developing and improving rules and regulations of those PAs who are certified. The House voted to continue to promulgate the definition of direct personal supervision which was adopted at the 1978 Annual Session.

Legal Age for Purchase of Alcohol

In an effort to reduce the teenage alcoholism problem and related accidents and deaths, a resolution requesting that MAG sponsor a bill in the 1980 Georgia General Assembly to raise the legal age for purchase of alcoholic beverages to age 20 was approved.

Legislation — Prescription of Medication

The supplemental report of the Committee on Legislation outlined pertinent points relative to the Georgia Pharmacy Act, Georgia Code 79-A, and the rules of the Georgia State Board of Pharmacy. The House approved the recommendations of the Committee on Legislation, one of which is to advise the membership of MAG of these laws. One interpretation is of particular importance: "No one other than those persons licensed and defined as a practitioner or practitioner of the healing arts (physician, dentist, or veterinarian, or others licensed to prescribe medications) can legally sign a prescription or telephone or communicate the origination of a prescription to a licensed pharmacy in this state."

Goal Setting

Dr. Joe Stubbs from Valdosta, chairman of the Board of Directors, recommended that the Board identify goals and objectives of the Association and establish both long and short term priorities. The Board should report to the House of Delegates on a regular basis regarding this endeavor.

National Catastrophic Insurance

A resolution by the Bibb County Medical Society prompted the passage of a resolution stating MAG's opposition to National Catastrophic Medical Insurance. The resolution urged that the serious matter of catastrophic illnesses and insurance be addressed at the state level.

Hospital Satellite Clinics

A resolution was adopted that disapproves of the concept of satellite hospital clinics and "branch office" emergency rooms in locations remote from the primary hospital site.

Education

MAG agreed to support regional directors of continuing medical education (CME) to assist hospitals in developing accredited CME programs. MAG adopted a policy statement on CME which sets a 5-year goal of having 100% of MAG members qualify for the AMA's Physician's Recognition Award. The House also voted to pursue a more vigorous campaign to eliminate smoking in health care facilities.

Health Systems Agencies

MAG will initiate efforts to stimulate physician interest in health planning through the coordination of physician task forces in each health service area. Physicians will be encouraged to become more active in their health systems agencies (HSAs). MAG will also work to inform our congressional delegation of problems observed in connection with the HSAs. They will be advised to review the effectiveness of the HSAs before voting for further funding. The MAG will work for repeal of the Certificate of Need legislation enacted in 1979 by the Georgia General Assembly.

PSRO

MAG voted to request the AMA to adopt a stance opposing funding for PSROs in the national budget each year.

Second Opinions

The House approved encouraging the use of consultations regarding elective surgery as a voluntary option for the patient and opposes any interference in the patient-physician relationship as a result of mandated or coerced second opinions.

Fees

Action was deferred regarding establishment of a statewide fee schedule under Medicare and Medicaid. The House endorsed the concept of usual, customary, and reasonable fees and opposed the discriminatory application of this concept in different geographic locations in the state.

County Coroner Systems

The House agreed to recommend to the Georgia Legislature that the county coroner system be abolished and replaced with a statewide medical examiner system.

Cost Awareness

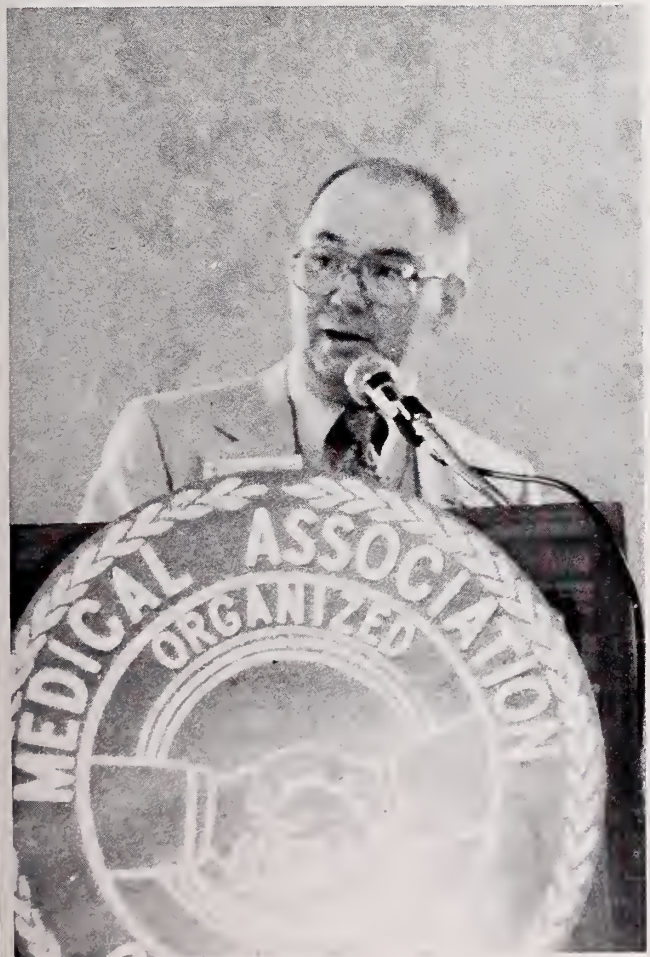
The House adopted a policy of recommending to hospital medical staffs that all tests performed in hospitals be ordered by physicians, except as required by state law. The House also agreed to inform third party carriers that MAG considers it highly desirable to encourage performance of appropriate surgery on an outpatient basis by providing adequate payments.


M.A.G.



Medical Association of Georgia 1979 Annual Business Meeting

Friday, April 20



Carson B. Burgstiner, M.D., calls the 1979 House of Delegates to order.

THE FIRST GENERAL SESSION of the 1979 Annual Business Meeting (House of Delegates) of the Medical Association of Georgia (MAG) was called to order by the president, Carson B. Burgstiner, M.D., of Savannah at 9:10 a.m., April 20, 1979, in the Ballroom at the DeSoto Hilton Hotel, Savannah, Georgia.

Dr. Burgstiner introduced the Reverend James W. Chester, pastor of the Isle of Hope United Methodist Church, Savannah, who gave the invocation.

For the opening ceremony, Harrison L. Rogers Jr., M.D., led the assembly in the Pledge of Allegiance, and Mrs. Roland Summers of Savannah played the National Anthem.

Dr. Burgstiner then read the names of MAG members who had died since the 1978 Annual Session. They were as follows:

MAG Deceased Members

Charles D. Adams, Atlanta
Thomas M. Adams, Montezuma
Yasuyuki Akamatsu, Augusta
H. H. Allen, Atlanta
Oliver Arteaga, Atlanta
Samuel U. Braly, Dallas
James E. Cantrell, Atlanta
Jesse F. Casey, Atlanta
Samuel B. Chyatte, Atlanta
James C. Coberly, Decatur
Charles H. Dickens, Madison
John J. Doolan Jr., Savannah
J. Rufus Evans, Stone Mountain
John R. Fair, Augusta



Mrs. Nony McMichael, 1978-79 President of the MAG Auxiliary, addresses the delegates.



The Honorable John P. Rousakis, Mayor of Savannah, welcomes MAG delegates to his city.

John J. Farris, Bartow
George W. Fuller, Atlanta
William Fulmer, Savannah
William L. Funkhouser Sr., Atlanta
D. H. Garrison, Clarkesville
John S. Guerrant, Dalton
William A. Hendry Sr., Blackshear
John W. Herndon, Douglas
James W. Howard, Atlanta
David J. Hughes, Atlanta
Dan A. Jardine, Douglas
Albert S. Johnson Sr., Elberton
Thomas W. Jones, Atlanta
William R. Jones, Columbus
Charles M. Kilpatrick, Augusta
J. Lon King Sr., Macon
Fred P. Manget, Macon, Atlanta
Marcus Mashburn Sr., Cumming
John R. McCain, Atlanta
David D. Merren, Albany
Richard W. Moore, Savannah
W. L. Moore, Rome
William A. Noble, Atlanta
Elton S. Osborne Sr., Savannah
Lewis L. Rawls, Macon
Keith C. Rice, Atlanta
Charles Rieser, Atlanta
B. J. Roberts, Cornelia
Barrett F. Rosen, Nashville, Tennessee
Shelton P. Sanford, Athens, Savannah
Walter L. Shepeard, Augusta
Robert P. Shinall Jr., Decatur
Jacob L. Shirley Sr., Dawson
Herman L. Siegler, East Point
Evelyn Swilling, Macon
Raymond Suarez, Macon
Claud V. Vansant Sr., Douglasville
Margaret J. Wall, Atlanta
William C. Ward, Atlanta
Richard B. Wilson, Atlanta
D. Lloyd Wood, Dalton
Joseph Yampolsky, Atlanta
Vehbi E. Yucel, Atlanta

Following the memorial service, Dr. Burgstiner introduced Robert Logan, M.D., president of the Georgia Medical Society, who, in turn, introduced the Honorable John P. Rousakis, Mayor of the City of Savannah. Dr. Logan and Mayor Rousakis both extended official greetings to the assembly from the host county medical society and from the City of Savannah.

Introduction of Distinguished Guests

Dr. Burgstiner introduced several distinguished guests: Douglas Skelton, M.D., commissioner, Georgia Department of Human Resources; Mr. Ted Snyder, Prudential Insurance Company of America; Mr. Robert Thompson and Mr. Frank Riley, Blue Cross/Blue Shield — Columbus; Mr. Jim Willis and Mr. Daryl Fischer, Health Care Financing Administration, Department of Health, Education, and Welfare; Mr. Les Landry, president, Georgia Association of Physician's Assistants; Mr. Tom Kinser and Mr. Rod Witmer, Blue Cross/Blue Shield — Atlanta; Mr. O. W. (Bud) Wright, Director of Federation Communications, American Medical Association (AMA); and Mr. Cecil Clifton, Executive Director of the Composite State Board of Medical Examiners. Mr. Clifton addressed the House briefly on progress being made by the Composite State Board of Medical Examiners.

At this point, Dr. Burgstiner introduced Mrs. Nony McMichael of Macon, president of the Auxiliary to the MAG. Mrs. McMichael gave a brief report on the activities of the Auxiliary during the past year and introduced a special guest, Mrs. Wayne C. Brady of Greenville, South Carolina, a member of the Board of Directors of the Auxiliary to the AMA. Mrs. Brady extended greetings from the AMA Auxiliary Board, and made brief remarks, listing a few of the accomplishments of the AMA Auxiliary.

Mrs. McMichael then presented Mrs. Walter S. Gresham of Bowdon, Georgia, who, in turn, introduced her daughter, Kim, president of the Georgia Allied Health Clubs. Kim addressed the assembly briefly, highlighting some of the activities of the Allied Health Careers Club.

Dr. Burgstiner called on Earnest C. Atkins, M.D., president-elect of MAG, who spoke briefly on his forthcoming administration.



Dr. F. G. Eldridge of Valdosta was honored for his longtime service to the Association as an AMA Alternate Delegate and as President of the MAG.

AMA-ERF Checks

Dr. Burgstiner presented the three Georgia medical schools unrestricted grant monies in the form of AMA-ERF checks, raised by contributions from the physicians and the Auxiliary during the previous year. Dr. Burgstiner presented checks as follows: to the Medical College of Georgia, a check in the amount of $7,035.63; to the Emory University School of Medicine, a check in the amount of $7,707.86; and to the School of Medicine at Morehouse College, a check in the amount of $1,000.00.

Following several brief announcements, Dr. Burgstiner adjourned the First General Session at 10:10 a.m.



(L) Drs. Carson Burgstiner, Earnest Atkins, and Milton Johnson at the House meeting.



(L) Drs. William Bailey, Macon, and Rupert Bramblett, Cumming.

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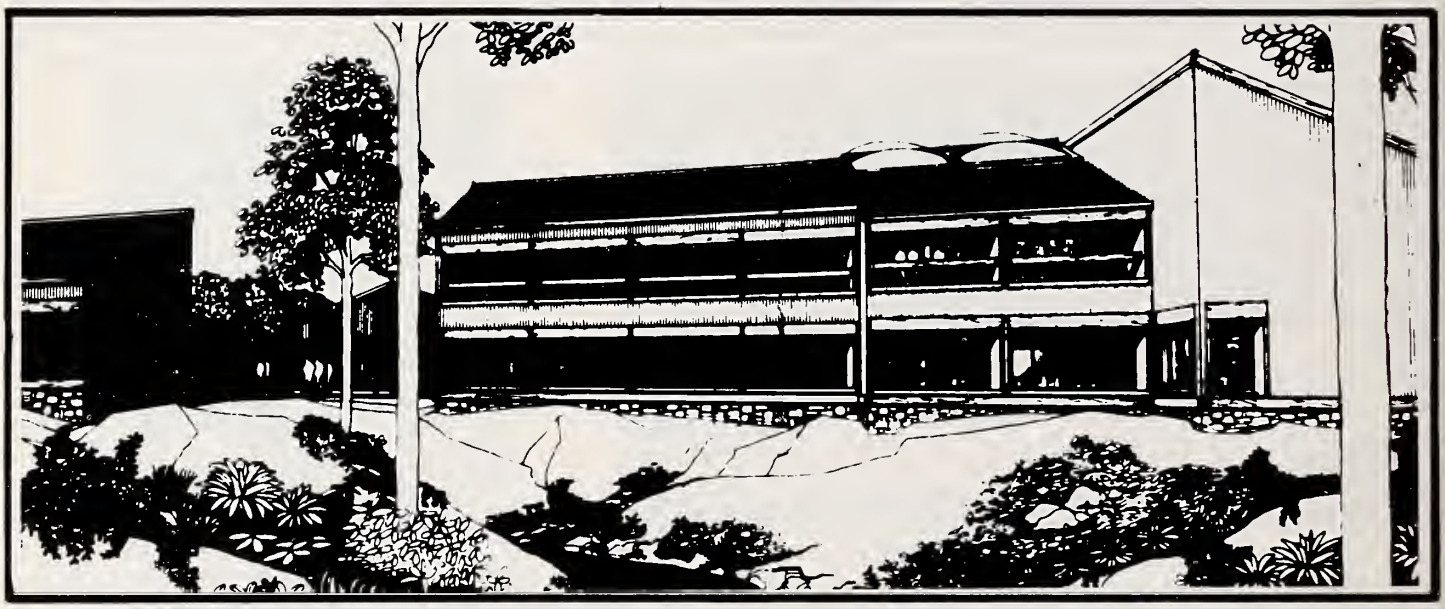
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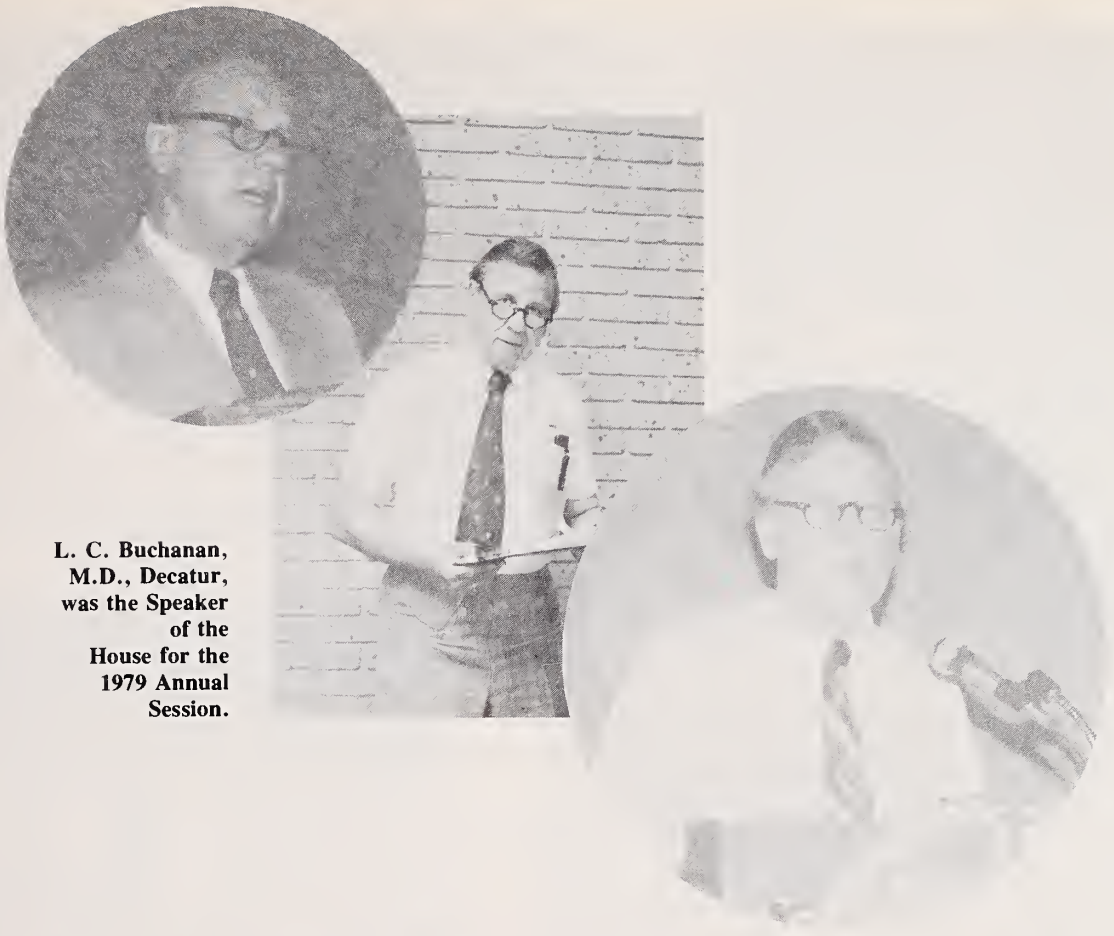


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L. C. Buchanan, M.D., Decatur, was the Speaker of the House for the 1979 Annual Session.

First Session, House of Delegates

Friday, April 20

THE FIRST SESSION of the House of Delegates was called to order by the speaker, L. C. Buchanan, M.D., at 10:20 a.m., Friday, April 20, 1979, in the Ballroom of the DeSoto Hilton Hotel, Savannah, Georgia.

The Speaker extended greetings to all delegates and briefly outlined the responsibilities of the House and the procedure to be followed during the three sessions of the House on April 20, 21, and 22, 1979.

The Speaker called for the report of the delegates in attendance. Edwin C. Evans, M.D., reported that 150 delegates, representing 44 component county medical societies were present, and accordingly announced that a quorum of the House was present.

Attendance

DELEGATES: BALDWIN: Mahmud Majanovic, W. T. Smith, Pedro Tamayo; BARROW: Hugh O. Hodges; BARTOW: Richard A. Griffin III; BIBB: David J. Frolich, Cyler D. Garner, Herbert S. Greenwald Jr., C. E. Johnson Jr., C. G. Magnan Jr., Jack F. Menendez, Beverly B. Sanders Jr., Loren Stahl, Alexander H. S. Weaver; OGEECHEE RIVER: Leon E. Curry, Charles R. Richardson; CARROLL-HARALSON: J. Larry Boss, Walter S. Gresham; GEORGIA MEDICAL SOCIETY: Edgar J. Filson, O. Emerson Ham Jr., J. Moultrie Lee, James R. Logan, Joseph V. Morrison Jr., Joseph A. Mulherin, D. A. Nash, Joe L. Nettles, Eloise B. Sherman, Dan H. Willoughby, Donald A. Wright; CHATTAHOOCHEE: Rupert H. Bramblett, Cecil L. Miller; CHEROKEE-PICKENS: D. T. Darnell; CRAWFORD W. LONG: E. V. Herrin, Robert Kelley, A. D. Muse Jr., Larkus H. Pesnell; CLAYTON-FAYETTE: William McDavid, Wells Riley; COBB: J. S. Bethea, Richard W. Cohen, Philip Z. Israel, Frank W. McKinnon, Spencer G. Mullins, J. Gary Palmer Jr., Harry Porter Jr., Charles J. Rey Jr., Gerald E. Sanders, Dan B. Stephens, Charles R. Underwood; COFFEE: William R. Wills Jr.; COLQUITT: Lanny R. Copeland; DECATUR-SEMINOLE: Frank L. Gibson; DEKALB: Stanley P. Aldridge, H. Duane Blair, L. C. Buchanan, William R. Hardcastle, John P. Heard, Richard Mattison, Charles W. McDowell Jr., LaMar S. McGinnis Jr., Walker L. Ray, Clyde B. Rountree, O. Wytch Stubbs Jr., Ralph A. Tillman, Theodore C. Whitson; DOUGHERTY: J. Dan Bateman, D. Morton Boyette, Carl V. Hancock Jr., Charles D. Hollis Jr.; CAMDEN-CHARLTON: Joseph M. Jackson; FLINT: Joseph T. Christmas; FLOYD-POLK-CHATTOOGA: Sidney A. Bell, Toby S. Morgan, Herman E. Spivey; FRANKLIN: Robert F. Sullivan; MEDICAL ASSOCIATION OF ATLANTA: Patrick Anders, Thomas J. Anderson Jr., Phillip R. Bartholomew, Allan C. Bleich, Spencer S. Brewer, Milton Bryant, E. Napier Burson Jr., William C. Collins, David E. Dalrymple, R. Carter Davis Jr., F. William Dowda, Richard E. DuBois, Julius Ehik, E. C. Evans, Louis H. Felder, Charles E. Harrison Jr., J. Harold Harrison, J. Rhodes



AMA Vice-Speaker, Harrison L. Rogers, Jr., M.D., speaks before the House of Delegates.



Parliamentarian Ronald Galloway (Augusta), and Teller Committee members T. A. Sappington, Claud A. Boyd, and Theodore C. Whitson.



Richmond County delegates J. Kenneth McDonald, President Charles H. Wray, and Joseph P. Bailey.

Haverty, William E. Huger Jr., J. R. B. Hutchinson, Fleming L. Jolley, W. Daniel Jordan, James A. Kaufmann, Spencer B. King III, Luella Klein, Bob G. Lanier, William D. Logan Jr., Joe B. Massey, John T. Mauldin, Arthur J. Merrill Jr., W. W. Moore, Hugo S. Moreno, Jeffrey T. Nugent, H. Dale Richardson, Harrison L. Rogers Jr., J. K. Schellack, William B. Spearman, Hugh S. Thompson Jr., Charles E. Todd Jr., L. Newton Turk III, Bozidar F. Voljavec, Edward J. Waits, William C. Waters III, Robert E. Wells, William H. Whaley, Frank L. Wilson Jr., J. S. Wilson, John T, Yauger; GLYNN: Michel A. Glucksman, Donald H. Manning, Edwin A. Mayo; HABERSHAM: Thomas N. Lumsden; HALL: Bradwell R. McAlister, Samuel Dean Rauch, John H. Reed Jr., James R. Wright; PEACH BELT: L. K. Raynor Jr., H. E. Weems; LAURENS: Robert W. Oliver, Quentin Price; MERIWETHER-HARRIS-TALBOT: Henry C. Jackson; MUSCOGEE: J. H. Deaton, Donald M. Kurtz, Bob R. Maughon, Edmund M. Molnar, Bruce C. Newsom, John S. Newton, Jack A. Raines, James H. Sullivan, William A. Wolff; NEWTON-ROCKDALE: Terrell B. Tanner; OCONEE VALLEY: H. A. Thornton; OCMULGEE: Myron Keith Lewis; RANDOLPH-STEWART-TERRELL: John G. Bates; RICHMOND: Donald C. Abele, Joseph P. Bailey, William E. Barfield Sr., Claud A. Boyd Jr., Leon H. Bush, Albert A. Carr, Thomas G. Douglass, Ronald F. Galloway, Robert Hill, Jimpsey B. Johnson, Julius T. Johnson, James Kenneth McDonald, James L. O'Quinn, Stuart H. Prather Jr., Luther M. Thomas Jr., Charles H. Wray; SOUTH GEORGIA: F. G. Eldridge, Joe C. Stubbs, William Threlkeld; SOUTHEAST GEORGIA: George W. Merritt; SPALDING: James M. Skinner; STEPHENS-RABUN: C. Peter Lampros, Irving D. Hellenga; ST. JOHN'S PARISH: Whitman Fraser; THOMAS AREA: Thomas F. Lear Jr., Frank R. Miller, Gerald B. Muller; TIFT: Stewart D. Gilbert, Robley D. Smith; TROUP: Joseph M. Almand Jr., J. W. Chambers, H. Hilt Hammett Jr.; UPSON: T. A. Sappington; WALKER-CATOOSA-DADE: Ted D. Cash, Charles Hillis; WARE: S. William Clark Jr., Floyd E. Davis; WHITFIELD-MURRAY: Robert W. Simmons, David A. Wells; WORTH: H. G. Davis Jr.

ALTERNATES: BIBB: Larry W. Grant, Kenneth C. Henderson, Alva Louie Mayes Jr., Ray H. McCard, Paul R. Phelps; OGEECHEE RIVER: C. Emory Bohler; DECATUR-SEMINOLE: Robert J. Starling; DEKALB: H. H. Carspecken, James C. Joiner III, Roy W. Vandiver, James A. Walker; DOUGHERTY: George M. Chastain, Chappell A. Collins Jr., L. T. Crimmins, Edwin E. Flournoy Jr.; FRANKLIN: William C. Ford; MEDICAL ASSOCIATION OF ATLANTA: Arthur S. Booth Jr., R. Lanier Jones; RICHMOND: Betty B. Wray; TROUP: M. Julian Duttera Jr.

Speaker Buchanan thanked the chairman of the Credentials Committee, and then presented the vice-speaker, Jack Menendez, M.D., of Macon to the assembly. The Speaker then appointed Ronald Galloway, M.D., of Augusta to act as parliamentarian during the 1979 meetings of the House.

Appointment of Committees

The Speaker announced the appointment of the House of Delegates Reference Committees, Credentials Committee, and Tellers Committee as follows:

Reference Committee A: H. Duane Blair, Decatur, Chairman; Ronald F. Galloway, Augusta, Vice-Chairman; Joe L. Nettles, Savannah; Charles R. Richardson, Statesboro; David Frolich, Macon; Arthur J. Merrill Jr., Atlanta.

Reference Committee B: William C. Waters III, Atlanta, Chairman; Donald Manning, Brunswick; Bradwell McAlister, Gainesville; J. Moultrie Lee, Savannah; Philip Z. Israel, Smyrna; O. Wytch Stubbs Jr., Tucker.

Reference Committee C: Rupert H. Bramblett, Cumming, Chairman; John P. Heard, Decatur, Vice-Chairman; Eloise B. Sherman, Savannah; Charles J. Rey Jr., Austell; A. D. Muse Jr., Athens; Hugo S. Moreno, East Point.

Reference Committee D: Luther M. Thomas Jr., Augusta, Chairman; Robert E. Wells, Atlanta, Vice-Chairman; D. Morton Boyette, Albany; Joseph A. Mulherin, Savannah; Jack A. Raines, Columbus; Richard A. Griffin III, Cartersville.

Reference Committee E: Alexander H. S. Weaver, Macon, Chairman; E. M. Molnar, Columbus, Vice-Chairman; Donald C. Abele, Augusta; H. E. Weems Jr., Perry; Joseph T. Christmas, Vienna; Spencer S. Brewer, Atlanta.

Reference Committee F: William E. Huger Jr., Atlanta, Chairman; Stuart H. Prather Jr., Augusta, Vice-Chairman; Cyler D. Garner, Gordon; George W. Merritt, Vidalia; William R. Hardcastle, Tucker; Dan B. Stephens, Marietta.

Tellers Committee: T. A. Sappington, Thomaston, Chairman; Theodore Whitson, Decatur; Hugh O. Hodges, Winder; Claud A. Boyd, Augusta.

Credentials Committee: Edwin C. Evans, Atlanta, Chairman; Robert W. Simmons, Dalton; Charles Hillis, LaFayette.

Adoption of Minutes

The Speaker announced that the proceedings of the 1978 Annual Session had been published in the July 1978 issue of the *Journal of the Medical Association of Georgia (JMAG)* and called for any corrections that should be made.

On motion duly made and seconded, it was voted that the proceedings of the 1978 meeting, as published in the July issue of the *JMAG,* be approved as published.

Nominations

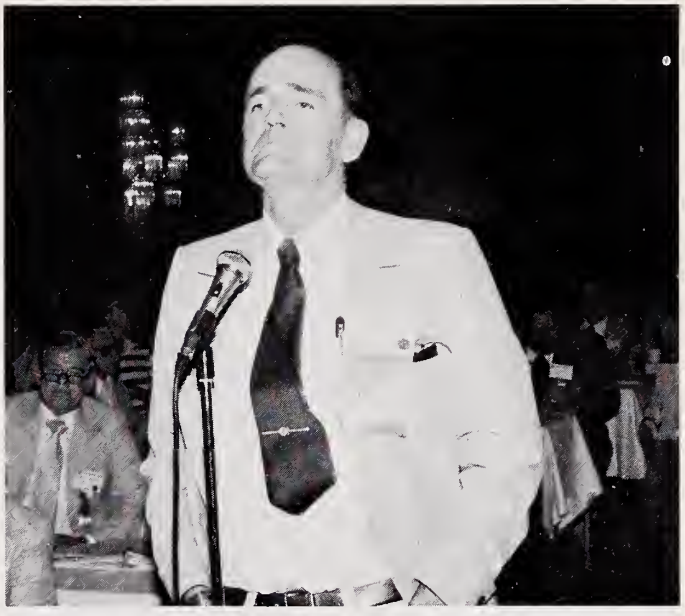
Speaker Buchanan called on the House to proceed with nominations for officers, AMA delegates and alternates, directors and alternate directors. He reminded the House that the election would be held on Sunday morning between 7 a.m. and 9 a.m., and that ballots would be provided by the Tellers Committee.

The Speaker asked for nominations for the office of MAG president-elect and the following nomination was made:

President-Elect: H. Hilt Hammett Jr., LaGrange, was nominated by J. W. Chambers, LaGrange. Dr. Hammett's candidacy was seconded by C. Emory Bohler, F. W. Dowda, E. M. Molnar, F. G. Eldridge, T. A. Sappington, John H. Robinson, Beverly B. Sanders, James Kaufmann, Ronald Galloway, and John Heard. There being no further nominations for the office of president-elect, the nominations were closed.

Second Vice-President: S. William Clark, Waycross, was nominated by Floyd Davis, Waycross. Dr. Clark's candidacy was seconded by Terrell Tanner, LaMar McGinnis, Charles Harrison, John Reed, and Robert Logan. There being no further nominations for the office of second vice-president, the nominations were closed.

AMA Delegate: Speaker Buchanan called for nominations for delegates to the AMA and for alternate delegates, observing that the term of all new delegates and alternates would begin on January 1, 1980.



AMA Delegate Dr. F. William Dowda speaking at his microphone before the House.

For the AMA Delegate seat currently held by F. William Dowda, Atlanta, Dr. Dowda was nominated by Harrison L. Rogers and seconded by Jeffrey T. Nugent.

For the AMA Delegate seat currently held by C. Emory Bohler, Brooklet, Dr. Bohler was nominated by Charles Richardson. Dr. Bohler's candidacy was seconded by James Sullivan, Thomas Anderson, and Leon Curry. There being no further nominations for the position of AMA Delegate, nominations were closed.

AMA Alternate: For the AMA Alternate seat currently held by F. G. Eldridge, Valdosta, Carson B. Burgstiner, Savannah, was nominated by F. G. Eldridge. Dr. Burgstiner's candidacy was seconded by Harrison L. Rogers, J. W. Chambers, C. Emory Bohler, and Robert Logan.

For the AMA Alternate Delegate seat currently held by Charles D. Hollis Jr., Albany, Dr. Hollis was nominated by J. Daniel Bateman, Albany. Dr. Hollis' candidacy was seconded by William Collins and F. William Dowda. There being no further nominations for the office of AMA Alternate Delegate, the nominations were closed.

Directors and Alternate Directors

Dr. Buchanan announced the results of the election for directors and alternate directors as conducted by the component medical societies:

First District Director: Leon E. Curry, Metter (1982). Alternate Director: Douglas O. Cope, Statesboro (1982).

Second District Director: J. Dan Bateman, Albany (1982). Alternate Director: Sammie Dixon, Tifton (1982).

Third District Director: V. W. McEver Jr., Warner Robins (1982). Alternate Director: Ken Raynor, Warner Robins (1982).

Georgia Medical Society Director: Joe L. Nettles, Savannah (1982). Alternate Director: Clyde L. Olson, Savannah (1982).

Medical Association of Atlanta Director: J. Harold Harrison, Atlanta (1982). Alternate Director: William C. Collins (1981), and William C. Waters III, Atlanta (1982).



Screening Late Resolutions

Speaker Buchanan announced the procedure for the screening of late resolutions to determine the urgency of such resolutions and thereby determine if they must be taken up at this meeting.

Annual Reports

Speaker Buchanan called for the Annual Reports of MAG officers, directors, committees, departments, and other reports to be introduced at this session which are listed below with the reference committee to which these reports were referred. (Editorial note: Each complete report, the recommendation of the reference committee, and the subsequent action taken by the House of Delegates on all reports referred to reference committees will be found under the proceedings of the Second Session, and the Third Session of the House of Delegates. See pages 569-612 and 621-652.

Officers' Reports

President — F
President Supplemental Report — F
President-Elect — Not Referred
First Vice-President — C
Second Vice-President — E
Chairman of the Board — C
Secretary — Not Referred
Treasurer — Not Referred
Speaker — D
Board of Directors (Budget) — F

Directors' Reports

AMA Delegation — E
First District Medical Society — Not Referred
Second District Medical Society — Not Referred
Third District Medical Society — Not Referred
Sixth District Medical Society — Not Referred
Seventh District Medical Society — Not Referred
Eighth District Medical Society — Not Referred
Ninth District Medical Society — Not Referred
Tenth District Medical Society — Not Referred
Bibb County Medical Society — Not Referred
Cobb County Medical Society — Not Referred
DeKalb Medical Society — Not Referred
Floyd-Polk-Chattooga Medical Society — Not Referred
Georgia Medical Society — Not Referred
Medical Association of Atlanta — Not Referred
Muscogee County Medical Society — Not Referred
Richmond County Medical Society — Not Referred

Committee Reports

Access to Health Care — E
Auxiliary — Not Referred
Cancer — C
Committee on Legislation — B
Committee on Legislation Supplemental — B
Constitution and Bylaws — E
Cost Accountability — D
Crawford W. Long Memorial — Not Referred



Delegates attend to House business.

Education — D
Emergency Medical Services — Not Referred
Georgia State Medical Association Liaison — E
Health Planning Committee — D
Laboratory Quality — Not Referred
Maternal and Infant Health — Not Referred
Medical Practice Committee — C
Medicine and Human Values — Not Referred
Membership — E
Mental Health — Not Referred
Nursing — B
Nutrition — E
Occupational Health — Not Referred
Peer Review — Not Referred
Physician-Lawyer Liaison — Not Referred
Physician's Assistants — B
Physician's Consultant Committee to the Disabled Doctors Program — A
Prison Health Care — F
Prison Health Care Supplemental — F
Professional Conduct and Medical Ethics — A
Public Health — Not Referred
Public Relations — C
Scientific Assembly — Not Referred
Third Party Relations — A
Transfusions and Transplantations — Not Referred

Department Reports

Auxiliary to MAG — Not Referred
Georgia Medical Care Foundation — Not Referred
Journal of the Medical Association of Georgia — Not Referred
MAG Services, Inc. — Not Referred

The Speaker called attention to the reports which are shown as having no recommendations and thus have not been referred to any reference committee. He called upon the delegates to request referral of any report they want to go to a reference committee. The Speaker then announced that all reports not referred to a reference committee would be filed for information. They are as follows:

OFFICE OF PRESIDENT-ELECT

Earnest C. Atkins, M.D., President-Elect

Thank you for electing me President of the Medical Association of Georgia for the coming year. Your confidence is appreciated, and your help is requested.

You have invited me to your local meetings, and I have thoroughly enjoyed these visits. I solicit these invitations during the coming year. My thoughts and my message to you will remain unchanged — better patient care through membership and unity in organized medicine.

We should continue to make better patient care our number one goal and, although this thought is not original, we should do unto our patients as we would have them do unto us.

The MAG has innumerable accomplishments to our credit. You are aware of them, and you are responsible for them.

Organized medicine has many enemies from without and, unfortunately, from within. The one thing that will

defeat us for sure is allowing ourselves to be divided into factions. As I visit our local societies and also national meetings, I find small groups, and in some instances large groups, that have one issue splitting them off from the mainstream of organized medicine. Some of these issues are: National Health Insurance, PSRO, unified membership, the chiropractic lawsuit in Pennsylvania, GaMPAC, and other issues. In many cases, these are so important to us that we stop being a part of organized medicine.

If we don't like what the local, state, and federal governments are doing to our patients, we have two choices: 1) Roll over and play dead; or 2) Fight! The secret to winning is membership, organization, and unity. We can achieve this goal through our present system of medical organizations — local, MAG, and AMA.

If 80% of us were together, we could tell the city, county, state, and federal governments how we will practice medicine — always for the best interest of our patients. Remember these two key words — membership and unity.

In the movie, "Rocky," he said, "I just want to go the distance." I am going the distance for our patients through our present system of organized medicine.

Thank you for being in my corner.

SECRETARY

William D. Logan Jr., M.D.

The Medical Association of Georgia continues to be a viable, flexible, and changing organization. My position as your new Secretary has been exciting as I have made efforts to better acquaint myself with all the functions and workings of the MAG. It has been very difficult to fill the shoes of my predecessor, Dr. Earnest C. Atkins, who did such a great job. The willingness and patience of Mr. Moffett and staff have been invaluable. I hope I can serve you more ably in the coming year.

In addition to the general direct organizational work of the society, there are several projects that need to be mentioned.

Information Systems: The Information Systems function at MAG was begun in 1974 to meet the needs of the EMCRO project. Since then it has grown to include a staff of four data processing professionals and provides computer services to virtually every department of the Association and the Georgia Medical Care Foundation.

The most significant event of 1979 in the data processing area at MAG will be the result of MAG's bidding on the PSRO data processing contract. At the time this report was prepared this contract was scheduled to be awarded approximately July 15.

Currently, the computer is used to process payrolls for both MAG and the Foundation. The MAG Membership Information System, which includes membership records, dues accounting, and mailing list preparation is on-line to the computer. It exchanges information directly with AMA's computer via magnetic tape. The Information Systems' staff has been working with officers and executives of MAG's county medical societies and with the AMA to enhance the system to provide positive control over the function of updating the computer records.

The computer is also used by the Georgia Cancer Registry which MAG operates under contract to the state to maintain an index of tumor patients at more than 20 Georgia hospitals. This service, which is free to the hospitals, is not only a valuable research tool, it also helps the hospitals to meet the American College of Surgeons' accreditation requirements.

For the Foundation, the computer is used for financial data processing. An index of about 80,000 Medicaid patients and about 8,000 providers has allowed a room full of filing cabinets to be replaced with computer terminals and microfilm equipment.

By the time you read this report, MAG will be on the way to automating its Physician Placement Service, providing better and faster responses than were possible by hand. This service is a valuable aid to all Georgians, especially those in rural areas. It furnishes physicians planning to relocate to Georgia with opportunity information and is a useful membership recruitment tool.

Georgia Cancer Registry Update: The Georgia Cancer Registry is currently operating under a 10-month contract from the Department of Human Resources. The program was funded again in July of 1978 for the same amount as in previous years ($69,500.00). Because of increased costs, this funding is adequate for only 10 months of operation. It is hoped that supplemental monies will be available for continuation of the program to June 30, 1979.

Twenty-four Georgia hospitals are affiliated with the program. Six of these are located in the metro area, while the remaining 18 facilities are located in outlying districts. These hospitals have submitted information on 69,472 cancer cases in Georgia. This figure reflects most of the 1977 cases with analytical data going back to 1967. Non-analytical data is available on cases treated as far back as 1940. Numerous reports are issued to the participating hospitals and Georgia physicians utilizing this data.

HSA Task Forces: A detailed report on the activities of the Health Planning Committee has been filed with the House of Delegates, and I shall not delve at length on these activities here. However, their efforts to organize physician task forces in each of the HSA areas in the state merit special mention here, if for no other reason than to emphasize and underscore their importance.

After a year of trying very hard to get a task force organized and functioning in each HSA area, we have been successful in only two localities: North Central Georgia HSA and the Southeast (coastal) Georgia HSA.

The purpose of the task forces is to provide a mechanism that parallels the structure of the HSA Board, with a view toward multiplying physician input and thus increasing physician influence. The mechanism will, hopefully, improve the odds that confront the vastly outnumbered physicians on each of our HSA Board of Directors.

It is my hope that more support will be forthcoming from our members and that this very important activity will progressively develop.

MAG and Affiliated Personnel: Personnel at MAG and in its related programs and projects is as follows:

	1979		*1978*
MAG Auxiliary	0		0
MAG (including Secretary, Treasurer & *Journal* Editor)	20		18
Information Systems	5		5
Tumor Registry	2		2
Prison Health Care	2		2
MAG Services, Inc.	2.5		2
Georgia Medical Care Foundation	57	(full/part time)	34
GMCF/PSRO (as of 4/1/79)	10		1

Membership: Membership continues very high on our priority list. Below is a 5-year report on the status of MAG and AMA membership in Georgia. The MAG figures are broken down by category of membership, both dues-paying and dues-exempt. You will note a precipitous decline in the number of Associate members, i.e., down from 115 to 8 in a year's span. You will of course recall that the House of Delegates amended the Bylaws at the last Annual Session to re-define Associate members as *only* Interns, Residents, and those individual physicians specifically granted Associate membership by their county medical societies.

	1978	*1977*	*1976*	*1975*	*1974*
Active	4,060	3,978	3,827	3,741	3,738
Active, I&R (Interns & Residents)	35	32	47	40	24
DE-1 (Financial Hardship/Illness)	64	60	61	65	59
DE-2 (Post-graduate Training)	11	10	15	15	19
DE-3 (Retired)	83	64	32	32	--
DE-4 (Temp. Duty, Armed Forces)	10	10	11	12	11
DE-5 (Life)	205	196	191	191	167
Associate	8	115	93	99	133
Service	64	66	66	62	55
Honorary	0	0	1	1	1
Affiliate	8	3	2	2	1
Student	1	3	2	2	2
DE-7	(65)				
Totals	4,549 (4,614)	4,547	4,348	4,262	4,210
AMA Membership	3,524	3,456	3,347	3,259	3,264

Much can be done in this area, and each of us needs to work individually and collectively for this goal.

Continued Medical Education: Continued medical education remains of great interest to me. Some of our most talented and able members serve MAG in this field and have kept Georgia in the forefront on the national scene. With added support to the Education Committee and Subcommittee, MAG can be a leader in this area and our patients and community will benefit.

TREASURER

James H. Sullivan, M.D.

If all budget requests were granted from all sources, we would have to raise the dues of MAG. It is up to the Finance Committee to recommend to the Board of Directors and to the House of Delegates through Reference Committee F to stay within our budget.

The House of Delegates has ruled that the MAG cannot deficit spend or deficit budget. We have the same situation in state government, which is the only way to operate. There are many state legislatures at the present time recommending to the Congress of the United States that the federal government not have deficit financing.

In order for us not to have to ask for a dues increase, we need the cooperation of the Finance Committee, Reference Committee F, and all MAG Committee Chairmen in submitting reasonable budget requests and if necessary, appealing to this House of Delegates for fiscal restraint.

Inflation or not, 1978 and 1979 was the fiscal year of MAG's first million dollar budget. Our financial standing is excellent and as promised, the utilization of funds has been closely scrutinized with emphasis on austerity, planning and fiscal responsibility. We are commanding at the present time the highest rate of interest available for our savings account. This is being negotiated with the bank on a monthly basis. We are in excellent financial condition, and this fiscal year was the first in quite some time that we have operated without indirect cost reimbursement from the federal government. The loss of Champus and the MAG's direction of this program has been severe on the MAG. But we have shown that MAG can operate without federal money, and we are equally sure that the medical profession can operate superbly without any government interference as well.

The budget and the dues structure of MAG has become more stabilized in the past several years, as we have attempted to hold down large expenditures of funds at the Executive Committee and the Board of Directors meetings by having financial requests directed through the Finance Committee or the office of Treasurer prior to any of the meetings. By thoroughly investigating all requests which we have received, we have been able to determine if the expenditures were necessary and in many cases, cutting the request and still allowing a program or project to be implemented at a great savings to our treasury.

We have again increased the sinking fund for land and ground acquisition in anticipation of a future move of the MAG Headquarters. The MAG benevolent fund is financially stable and self-sustaining. Our individual association committees have again done an excellent job. The expenditure of funds by each of our committees has been absolutely necessary, and the application of these funds have been extremely efficient. I wish to commend our committees and each MAG employee who staffs them for this efficiency.

GaMPAC is a very important viable part of our organization, and each of us in MAG owes a tremendous debt to the hard workers in GaMPAC for their political activism. Because of GaMPAC's great contribution in the political arena to our association and its members, our Legislative Committee and staff time and effort and the expenditure of funds has been kept to a minimum. Without GaMPAC's participation, our legislative work would require many more man-hours and certainly put a large strain on our funds.

With the monthly rise in inflation, with the increase in federal taxes and social security, and with uncertain times ahead of us, I believe MAG remains ahead of any financial difficulty. With the cooperation of all committees, the Executive Committee, the Board of Directors and our members, we will be able to live within our budget, not increase our dues, and not prevail on this House of Delegates for a dues increase in the near future and certainly demonstrate the private enterprise way of life.

It is a pleasure to serve as Treasurer of an organization which is adequately financed in the best private enterprise manner, and I have enjoyed very much working for the MAG in this position. I would like to personally thank Mr. L. B. Storey Jr. who continually demonstrates an extreme dedication to the MAG. Without his knowledge of financial affairs, accounting, and business attitude, the office of Treasurer and the MAG itself could not be a viable, enthusiastic, financially secure private enterprise type of organization. Again, I appreciate the help of Mr. Storey, the Executive Committee, the Board of Directors, and the entire House of Delegates.

REPORTS OF DIRECTORS

FIRST DISTRICT MEDICAL SOCIETY

Leon E. Curry, M.D., Director

Counties and Secretaries	Members 12/31/77 MAG	Members 12/31/77 AMA Dues Paying	Members 12/31/78 MAG	Members 12/31/78 AMA Dues Paying
Ogeechee River H. Randolph Smith Statesboro	33	27	35	26
Burke Walter R. Voyles Waynesboro	4	3	4	3
Emanuel Chang Kue Kim Swainsboro	5	4	6	4
Laurens Grady E. Longino Dublin	35	22	37	21
Screven James C. Freeman Sylvania	6	6	5	5
Southeast Georgia James E. Barfield Vidalia	11	5	12	5
St. John's Parish Chen-Wen Shih Hinesville	7	0	10	0
TOTAL	101	67	109	64

SECOND DISTRICT MEDICAL SOCIETY

J. Dan Bateman, M.D., Director

Counties and Secretaries	Members 12/31/77 MAG	Members 12/31/77 AMA Dues Paying	Members 12/31/78 MAG	Members 12/31/78 AMA Dues Paying
Colquitt Leonard LaConte Moultrie	20	16	17	14
Decatur-Seminole N. G. Matucan Bainbridge	14	9	12	9
Dougherty R. L. McKinney Albany	92	72	90	69
Mitchell A. A. McNeill Jr. Camilla	5	3	6	4
Southwest Georgia V. M. Saxena Fort Gaines	11	2	10	1
Thomas Area Thomas E. Arnett Thomasville	51	35	51	35
Tift T. W. Hayes Tifton	26	15	25	17
Worth F. L. McLean Sylvester	5	2	4	1
TOTAL	224	154	215	150

THIRD DISTRICT MEDICAL SOCIETY

John H. Robinson III, M.D., Director

Let us maintain our determination to make voluntary cost containment an effective agent in fighting inflation.

Counties and Secretaries	Members 12/31/77 MAG	Members 12/31/77 AMA Dues Paying	Members 12/31/78 MAG	Members 12/31/78 AMA Dues Paying
Flint Charles C. Greer III Cordele	18	11	18	11
Peach Belt Charlie Dean Perry	45	40	43	34
Randolph-Stewart-Terrell Thomas Allen Dawson	5	5	5	5
Sumter William R. Anderson Americus	20	13	19	11
TOTAL	88	69	85	60

SIXTH DISTRICT MEDICAL SOCIETY

James M. Skinner, M.D., Director

Counties and Secretaries	Members 12/31/77 MAG	Members 12/31/77 AMA Dues Paying	Members 12/31/78 MAG	Members 12/31/78 AMA Dues Paying
Clayton-Fayette Elizabeth Hadley Riverdale	54	28	62	26
Coweta G. M. McNabb Newnan	26	20	23	19
Meriwether-Harris-Talbot William G. Chambless Hamilton	8	6	8	7
Spalding Leiv M. Takle Griffin	36	31	36	30
Troup John T. West LaGrange	39	36	50	37
Upson C. W. Dodgen Thomaston	22	16	26	14
TOTAL	185	137	205	143



These times of ours are serious and full of calamity, but all times are essentially alike.

Ralph W. Emerson:
Lecture on Public and Private Education,
Boston, Nov. 27, 1864.

SEVENTH DISTRICT MEDICAL SOCIETY

Richard A. Griffin III, M.D., Director

Counties and Secretaries	Members 12/31/77 MAG	Members 12/31/77 AMA Dues Paying	Members 12/31/78 MAG	Members 12/31/78 AMA Dues Paying
Bartow William B. Dillard Cartersville	8	7	8	6
Carroll-Douglas-Haralson* John E. Godard Carrollton	45	30	43	31
Gordon Bill Purcell Calhoun	9	7	7	5
Walker-Catoosa-Dade Thomas E. Hayes Chattanooga, TN	40	26	37	24
Whitfield-Murray Rodger H. Eidson Dalton	62	44	58	46
TOTAL	164	114	153	112

*** Carroll-Douglas-Haralson County Medical Society is now Carroll-Haralson County Medical Society, as of 1/1/79; Douglas County has formed the Douglas County Medical Society.**

EIGHTH DISTRICT MEDICAL SOCIETY

Joe C. Stubbs, M.D., Director

Counties and Secretaries	Members 12/31/77 MAG	Members 12/31/77 AMA Dues Paying	Members 12/31/78 MAG	Members 12/31/78 AMA Dues Paying
Altamaha C. B. Kanavage Baxley	3	1	3	2
Ben Hill-Irwin Ralph Roberts Fitzgerald	5	4	5	4
Coffee Jack G. Williams Douglas	17	11	17	12
Camden-Charlton Eduardo Oliveira St. Mary's	6	3	6	3
Glynn Fred Adickes St. Simons Island	64	44	67	42
Ocmulgee W. E. Coleman Hawkinsville	16	12	17	12
South Georgia Edwin Hiatt Valdosta	71	34	71	37
Telfair D. B. McRae McRae	6	5	4	3
Ware L. J. Duane Jr. Waycross	48	34	50	31
Wayne Robert L. Phillips Jesup	9	8	9	8
TOTAL	245	156	249	155

NINTH DISTRICT MEDICAL SOCIETY

Rupert H. Bramblett, M.D., Director

Counties and Secretaries	Members 12/31/77 MAG	Members 12/31/77 AMA Dues Paying	Members 12/31/78 MAG	Members 12/31/78 AMA Dues Paying
Barrow W. Q. Randolph Winder	8	3	7	3
Blue Ridge R. A. Burns Blue Ridge	(Disbanded)		3	2
Chattahoochee Rupert H. Bramblett Cumming	28	22	31	24
Cherokee-Pickens Robert T. Anderson Canton	19	8	16	9
Elbert M. H. Arnold Elberton	8	7	9	5
Franklin-Hart Robert F. Sullivan Carnesville	8	8	8	8
Habersham R. D. Doshi Demorest	13	7	11	7
Hall Charles N. Kelley Gainesville	87	64	97	76
Jackson-Banks Sam A. Vickery Commerce	7	4	6	4
Stephens-Rabun John Payton Toccoa	26	11	25	11
TOTAL	204	134	213	149

TENTH DISTRICT MEDICAL SOCIETY

M. A. Hubert, M.D., Director

The Tenth District Medical Society has had two good meetings during the past year and is trying to get better attendance at district meetings.

Counties and Secretaries	Members 12/31/77 MAG	Members 12/31/77 AMA Dues Paying	Members 12/31/78 MAG	Members 12/31/78 AMA Dues Paying
Baldwin Louis Jacobs Milledgeville	51	19	48	19
Crawford W. Long Ben C. Barrow Athens	80	61	76	55
Jefferson James B. Polhill Louisville	5	4	6	3
McDuffie M. N. Whaley Thomson	5	6	4	4
Newton-Rockdale Stephen Boyle Conyers	13	8	19	8

Oconee Valley				
J. Lee Parker				
Greensboro	10	8	9	7
Walton				
J. Howard Barton				
Social Circle	8	7	10	8
Washington				
William Rawlings				
Sandersville	7	2	7	2
Wilkes				
C. E. Pollock				
Washington	5	5	5	5
TOTAL	184	120	184	111

BIBB COUNTY MEDICAL SOCIETY

Beverly B. Sanders Jr., M.D., Director

County and Secretary	Members 12/31/77 MAG	Members 12/31/77 AMA Dues Paying	Members 12/31/78 MAG	Members 12/31/78 AMA Dues Paying
Bibb				
Herbert S. Greenwald				
Macon	207	152	215	161

COBB COUNTY MEDICAL SOCIETY

Charles R. Underwood, M.D., Director

Under the leadership of President Phil Israel, 1978-79 proved to be an active and productive one for the Cobb County Medical Society. With the presence of four major hospitals now active in the county, and carrying with them further cleavage of the medical community into hospital-based groups, real progress was made by the president in distributing committee responsibilities among the several hospital staff members and thus forging an alliance of the widely diverse groups in spite of this geographical separation. Several county-wide ventures have contributed to this effort to keep the county medical community as informed and organized as possible. The annual Installation of Officers Banquet continues to draw a full house of doctors with their wives, while the October Medical/Legal Dinner provides a significant opportunity for interchange between the two professions. In addition, the Society continues to host an annual Legislative Dinner during the winter legislative session to which all county legislators are invited, giving us an opportunity to provide significant input into the legislative process. Each year this has proven to be an even more valuable means of getting to know the legislators well enough to comfortably discuss medical issues confronting the General Assembly. The Cobb County Symposium is alive and drawing large crowds to the annual spring meeting which through the years has attracted outstanding speakers. The county society has initiated an "Honors Day Award" at Kennesaw College as well as a Memorial Scholarship Fund. Both of these efforts give the medical community an opportunity to have input into the student body of our local college.

The continued activity of the Women's Auxiliary to the Cobb County Medical Society is an annual source of pride to the members of the society. Their activities are many and varied — too many to barely innumerate — but outstanding among these are the CPR courses taught on a regular basis by Auxiliary members and now having been attended by the great majority of physicians and their families and office personnel in the community. A study manual for the CPR course has been developed by Dr. and Mrs. Robert Session. The Kennestone Hospital Gift Shop, administered by the Auxiliary, continues to grow and return significant profit margins back into the hospital for provision of equipment items not in the hospital budget, as well as supplying numerous new volumes to the medical library. Of particular help for the past year or so has been the creation by the Auxiliary of interpreters who are available to foreign language speaking patients in any of the county hospitals. Among the host of other activities carried on by the Auxiliary are the help rendered the Cobb County Symposium and the many organizational aspects of this significant meeting, contributions to the AMA-ERF, compilation of a local medical history by the Romance of Medicine Committee, and the organization of a Health Careers Day for local high school students. The physicians in this community could hardly be more proud of their ladies and the very significant activities which they carry on. We are proud, then, of the continued activity and accomplishments of the Cobb County Medical Society. Our active membership has grown over the past year from 268 to 285 members, while the number of non-society physicians in the county has decreased significantly. Frank McKinnon has taken office as the new president for the Cobb County Medical Society, continuing a long line of highly capable and respected local physicians who have served in this capacity. Our local society is alive and well — active in many areas of endeavor related both to service to our members and to the public at large — well organized, fiscally sound, and prepared for another active and productive year.

County and Secretary	Members 12/31/77 MAG	Members 12/31/77 AMA Dues Paying	Members 12/31/78 MAG	Members 12/31/78 AMA Dues Paying
Cobb				
Spencer Mullins				
Marietta	254	147	258	155

DEKALB MEDICAL SOCIETY

John P. Heard, M.D., Director
Roy W. Vandiver, M.D., Alternate Director

Dr. Roy Vandiver, Alternate Director, and I have instituted a newsletter which is mailed to all members of the DeKalb Medical Society following each meeting of the MAG Board of Directors to inform them of the pertinent actions at the meeting. The newsletter appears in an informational format, though there is some "tongue in cheek" involved. It is entitled the "John-Roy Report" with the following sub-heading "a compendium of minutia and other trivia from the Board of Directors of the Medical Association of Georgia." Roy and I share the expenses of the printing and mailing of this newsletter and have received very positive feedback from the membership.

Our Medical Society continues to struggle with the issue of unified membership and will again offer a resolution this year to rescind this policy. While our leadership supports a unified policy of membership, many of our members philosophically object to some positions taken by MAG and refuse to join the organization, thus causing a loss of membership in the county society. The primary objection we face, however, is the principle of mandating

membership in one organization in order to hold membership in another.

County and Secretary	Members 12/31/77 MAG	Members 12/31/77 AMA Dues Paying	Members 12/31/78 MAG	Members 12/31/78 AMA Dues Paying
DeKalb Ernest C. Fokes Jr. Decatur	278	197	288	199

FLOYD-POLK-CHATTOOGA MEDICAL SOCIETY

John I. Dickinson, M.D., Director

County and Secretary	Members 12/31/77 MAG	Members 12/31/77 AMA Dues Paying	Members 12/31/78 MAG	Members 12/31/78 AMA Dues Paying
Floyd-Polk-Chattooga Peter Gilbert Rome	101	64	101	71

GEORGIA MEDICAL SOCIETY

Joseph A. Mulherin, M.D., Director

County and Secretary	Members 12/31/77 MAG	Members 12/31/77 AMA Dues Paying	Members 12/31/78 MAG	Members 12/31/78 AMA Dues Paying
Georgia Medical Society Eloise B. Sherman Savannah	236	193	226	184

MEDICAL ASSOCIATION OF ATLANTA

John T. Godwin, M.D., Director

County and Secretary	Members 12/31/77 MAG	Members 12/31/77 AMA Dues Paying	Members 12/31/78 MAG	Members 12/31/78 AMA Dues Paying
Medical Association of Atlanta W. Ben Spearman Atlanta	1205	840	1204	804

MUSCOGEE COUNTY MEDICAL SOCIETY

Jack A. Raines, M.D., Director

County and Secretary	Members 12/31/77 MAG	Members 12/31/77 AMA Dues Paying	Members 12/31/78 MAG	Members 12/31/78 AMA Dues Paying
Muscogee County Medical Society Kenneth L. Goldman Columbus	202	136	211	156

RICHMOND COUNTY MEDICAL SOCIETY

Ronald F. Galloway, M.D., Director

The Richmond County Medical Society remains quite active. Attendance at the meetings remains good, and programs are well planned and interesting. Dr. Henry Scoggins has resigned as Alternate Director and has been replaced by Dr. Luther Thomas. I'm certain that Dr. Thomas will serve well. I have no specific recommendations to the House of Delegates for this report.

County and Secretary	Members 12/31/77 MAG	Members 12/31/77 AMA Dues Paying	Members 12/31/78 MAG	Members 12/31/78 AMA Dues Paying
Richmond County Medical Society Donald Abele Augusta	353	283	344	270

COMMITTEE ON AUXILIARY

Robert S. McMichael, M.D., Chairman

There has not been a meeting of the Committee on the Auxiliary this year, and one is not anticipated before the year ends. The Auxiliary seems to have the situation well in hand.

The Auxiliary has had another busy year with its many programs. Their activities embrace a full spectrum of health-related projects, fund raising for AMA-ERF, safety projects, the sponsorship of allied health careers clubs, legislative activities, and enrichment programs such as Doctors' Day and the Research and Romance of Medicine.

Each Auxiliary member, working through her county Auxiliary, has reached out and improved the quality of life for others.

CRAWFORD W. LONG MEMORIAL COMMITTEE

E. L. Frederickson, M.D., Chairman

The Committee for the Crawford W. Long Museum has not met, although as chairman I have been active on the Board of Directors of the museum [located in Jefferson]. As I mentioned in my previous report, we have had a consultant from the Howard Dittrick Museum to help us in planning the renovation of the inside of the museum, and the Museum Association has signed a contract with her.

We felt that it was now time to try to improve the inside of the museum, since the building itself has been weatherproofed and a new roof has been put on. The design for this interior renovation, as submitted by the consultant, calls for redesigning the first floor and most of the second floor, leaving an area on the second floor for a workroom and for storage, which has never been available there previously. We also were going to attempt to re-do all of the cases to bring them more up-to-date and made them more eye-appealing. One of the consultant's students is planning on spending the summer at the museum doing much of the cataloging and renovation that is needed.

The carpentry work is already starting, and an interior decorator has been obtained to help us plan the colors. At the present time, we are planning some other exhibit cases that will fit in with the time period to explain the state of medicine in 1842. It is hoped that all this renovation work will be totally completed by the end of this summer, and we hope that the members of MAG will very happily visit the museum this fall to see the results of the money they have so generously contributed.

EMERGENCY MEDICAL SERVICES COMMITTEE

Selwyn T. Hartley, M.D., Chairman

The Emergency Medical Services (EMS) Committee was reactivated in the Fall of 1978. The committee met once in November and discussed the new EMS law that gives control of EMS systems to District Health Officers. The committee also discussed the problem of inadequate physician supervision of Emergency Medical Technicians (EMT) and decided to seek further information on that problem. The committee also decided to take on the job of improving regional disaster plans in the state through the Civil Defense Network.

In addition, members of the committee recognized that SB 292 as originally written would allow EMTs to practice medicine. The EMS Committee was represented at the committee hearings and helped get the bill amended to delete the unacceptable language.

In the coming year the committee plans to:

1) Present recommendations to improve physician control of EMS systems.

2) Improve the emergency medical response in disaster through cooperation with the Civil Defense.

COMMITTEE ON LABORATORY QUALITY

Richard E. DuBois, M.D., Chairman

During 1978 there were no meetings of the Committee on Laboratory Quality. An attempt was made to establish a roster of consultant pathologists to whom laboratory directors could direct questions regarding performance of laboratory studies. This was unsuccessful. An attempt was made to distribute material on workshops, courses, and seminars for laboratory personnel to laboratory directors, and this was accomplished for state sponsored educational courses.

The charge to the Committee is to monitor and improve the quality of laboratory work performed in individual physicians' offices through the mechanism of voluntary participation and proficiency testing programs.

The State Health Department no longer has a proficiency testing program but does require proficiency testing for laboratory licensure. Similarly, Medicaid/Medicare also require proficiency testing programs to be in effect for listing of a laboratory as an approved laboratory for reimbursement. Furthermore, it is expected that additional legislation is soon forthcoming regarding laboratory studies performed in physicians' offices, as well as additional proficiency testing requirements.

Since such state and federal regulations are in effect, there is little need to promote a voluntary participation program. There are many laboratories in physicians' offices in Georgia which are neither licensed nor "approved" by Medicaid/Medicare; but, in general, these laboratories are smaller and perform lesser amounts of laboratory work. Proficiency testing for these laboratories is inordinately expensive, and it would seem fruitless to encourage voluntary participation in programs by these laboratories.

For the reasons stated above, it was recommended to the MAG Executive Committee that this committee be terminated.

MATERNAL AND INFANT HEALTH COMMITTEE

Luella Klein, M.D., Chairman

During 1978 the Committee on Maternal and Infant Health met several times to review maternal death cases and abortions in Georgia and to discuss maternal and infant health care and legislation. The Maternal and Child Health Unit of DHR provided the statistics included in the following report about Georgia:

Livebirths and Birth Rate

There were 84,432 livebirths in Georgia in 1977. Preliminary data indicate that there will be little or no increase in 1978.

There were 346 livebirths at home attended by lay midwives, and there were 1,538 deliveries in hospitals by Certified Nurse Midwives.

Births to Unwed Mothers

There were 11,926 livebirths to unwed mothers during 1977, a rate of 141.2 per thousand, an increase from 139.7/1000 in 1976.

Adolescent Pregnancies

Livebirths to adolescents under 20 represented 22.4% of births in 1977. There were 8,592 livebirths to mothers under age 18 out of a total of 18,935 adolescent livebirths. Of livebirths to unwed mothers, 30% were to adolescents under 18 and about 47% of under-18 teenaged livebirths were reported born out of wedlock. The percentage of livebirths to unwed mothers under 18 increased from 33% in 1976 to 47% in 1977.

Maternal Mortality

Nineteen women died as a direct or indirect result of pregnancy during 1976, 15 black and four white.

Ectopic pregnancy was the cause of death for two women. Toxemia of pregnancy was responsible or contributory in the deaths of four women. Pulmonary embolism contributed to three deaths, all of which were amniotic fluid emboli. Four deaths were associated with hemorrhage, and four related to Caesarian Section. One resulted from a self-induced abortion.

Infant Mortality

There were 1,427 infant deaths during 1977, a rate of 13.0/1000 livebirths for white and 23.7/1000 livebirths for black. White neonatal death rate was 8.9 and postneonatal 4.1. For black infants, the decline was to 14.9 for neonatal deaths but increased to 8.8 for postneonatal deaths. It should be noted that with the exception of the decline for black neonatal deaths, all these statistics represent an increase in infant mortality over 1976 statistics.

Abortion

During the calendar year 1977, there were 29,905 legal abortions reported to the Department of Human Resources; 26,552 were to residents of Georgia, and 3,240 were to out-of-state residents. This is an abortion ratio of 318.2 abortions per thousand livebirths. There were no deaths directly attributable to legal abortion.

Thirty-two percent of the abortions performed were to women under 20 years of age; 62% of these were to white women and 38% to black and others. Seventy-two percent

of the patients stated that they were unmarried. Sixty-seven percent reported that they were not practicing contraception prior to becoming pregnant, and 21.6% reported at least one previous abortion. Ninety-three percent of legal abortions were obtained under 13 weeks of gestation, 6% between 13 and 20 weeks, and 1% greater than 20 weeks. Eighty-two percent of the abortions were reported as "outpatient" procedures, and 92% of these were performed by suction curettage. Although the abortion ratio per 1000 livebirths decreased slightly from 1976, the percentages of unmarried patients, those not practicing contraception, and those with previous abortion increased.

Family Planning

As of June 30, 1978, there were 111,958 women actively participating in the Department of Human Resources statewide Family Planning Program. During fiscal year 1978, there was an unduplicated total of 149,954 patients served at 311,134 visits. Nearly one third of patients were under 20 years of age. Oral contraceptives were chosen by 61% of the patients, intrauterine devices by 10%, and other methods by 29%. There were 374 sterilization procedures paid for by program funds.

Cervical Cancer Screening Program

During fiscal year 1978, the statewide Cervical Cancer Screening Program sponsored by the Georgia Department of Human Resources provided 114,112 Pap smears to indigent and medically indigent patients receiving health services from local health clinics. Since the beginning of the program in 1967, a total of 818,272 Pap smears have been done, and a diagnosis of malignancy has been made in 1,215 cases. Over the duration of this program, annually about 1 percent of the Pap smears are reported as either suspicious or positive. Follow-up on these later cases has identified almost 15% as having an early asymptomatic malignancy. Ninety percent of all malignancies found have been preinvasive.

In accordance with established MAG policy, the Maternal and Infant Health Committee plans to enhance the educational aspects of the review of maternal deaths which are deemed preventable.

Also, the committee will attempt to work with other agencies to increase family life education in Georgia.

COMMITTEE ON MEDICINE AND HUMAN VALUES

Ronald M. Hudson, M.D., Chairman

The Committee's main activity during the past year was discussion and support of legislation which would authorize the discontinuance of life-sustaining procedures for patients with a terminal condition upon written directive (the so-called "living will") from the patient. The legislation was introduced in 1978 as House Bill 1258, passed the House of Representatives, and was killed in a Senate committee. In April, MAG's House of Delegates approved our Committee's recommendation that the MAG support such legislation.

Sometimes referred to as the "natural death act," the legislation described above was reintroduced in the 1979 session of the legislature as Senate Bill 86. Our Committee had the highly educational experience of going down to the State Capitol and participating in testimony and debate on the bill before the Senate Committee on Human Resources. Interestingly, the debate found our Committee and the MAG lobbyists on one side and several physicians speaking for a group of 50 Augusta physicians on the opposing side. Since the Senate Committee vote ended in a tie, the bill did not pass out of Committee to the full Senate. Our Committee will continue to monitor developments on this legislation.

Another subject of great interest to the Committee is the development of the hospice concept for human and palliative care of the terminally ill. The Committee welcomes any ideas and suggestions from MAG members on this or any other subject which touches upon human values in medicine.

MENTAL HEALTH COMMITTEE

Kenneth D. Jones, M.D., Chairman

The main thrust of committee activities this past year has been in the legislative area.

We have especially been interested in a bill on psychiatric insurance, extremely concerned and interested in the Senate bill on confidentiality. Most members have been quite active in contacting other members of the association, as well as other physicians and legislators that they know, concerning these legislative measures.

Except for review of some past legislation with myself and Senator Lester primarily on the latest mental health bill, as well as the latest alcohol bill and a bill having to do with mental retardation, there have been no further activities.

We do not have any recommendations for the coming year.

OCCUPATIONAL HEALTH COMMITTEE

Robert P. Cunningham, M.D., Chairman

The Occupational Health Committee met on July 26, 1978, to review and discuss the new Worker's Compensation Law — H.B. 1360. The Committee examined several concerns of the membership concerning the law and drafted an item for the MAG *Newsletter*. In addition, we submitted an article to Dr. Edgar Woody, Editor of the *Journal of the Medical Association of Georgia*.

The second meeting was on October 19, 1978, and a discussion was held regarding disability evaluation as it relates to the State Worker's Compensation Board. The Committee felt that efforts should be made toward the universal use of the AMA guide on evaluation of disability. A future meeting was planned to discuss this question and secure input from members of the Association representing the specialties of orthopedics and neurosurgery. The Committee plans to work toward the education of all members for a better understanding of the disability evaluation process.

PEER REVIEW COMMITTEE

Walter S. Dunbar, M.D., Chairman

With the expansion of review by specialty panels within the Georgia Medical Care Foundation (GMCF) and Metropolitan Atlanta Foundation for Medical Care (MAF) during the past 2 years, the function of the MAG Com-

mittee on Peer Review as a claims review mechanism has diminished.

In addition to review of cases which were appealed during the past year, the Committee has addressed such diverse problems as (1) medical necessity for amniotic fluid analysis for fetal chromosomal abnormality, (2) the establishment of guidelines to be used by the GMCF in determining a payment mechanism for cosurgeons, and (3) the needed modifications in the federally proposed guidelines for PSRO sanction of physicians. The problem of medical necessity for amniotic fluid analysis was referred to a subcommittee within the GMCF to be composed of representatives of all specialty groups involved, specifically to include person(s) trained in genetics. Recommendations were made to and implemented by the MAG Board of Directors relative to modifying the payment policy of cosurgeons and to improving the federally proposed guidelines for PSRO sanctions of physicians.

As the GMCF assumes the role of the PSRO in Georgia, the MAG Committee on Peer Review will continue to provide development of medical policy for peer review, to identify educational needs as demonstrated by peer review, to serve as final level of appeal for commercial claims, and to serve when needed as the interface committee between the MAG and the PSRO. It will also have the capacity of being an alternate review resource available to physicians electing to use it for claims not mandatorily subject to PSRO review. In this capacity it would be expected that the resources of the medical care foundations would be utilized initially as primary reviewing bodies.

PHYSICIAN-LAWYER LIAISON COMMITTEE

William E. Huger Jr., M.D., Chairman

The Physician-Lawyer Liaison Committee met in joint session in December 1978 at the time of the Georgia Bar Association meeting in Atlanta. At that time five complaints were presented to the Committee. One was spontaneously settled by its participants. One was settled by the legal chairman. Three were presented to the joint Committee, and the participants were notified of our recommendations. Dr. Lil James of Macon and Dr. Donald Chait of Atlanta have been appointed to the Committee for revision of the brochure, *Principles Governing Physician-Attorney Relationships.*

COMMITTEE ON PUBLIC HEALTH

J. Gary Palmer Jr., M.D., Chairman

The Committee did not meet during the past year and did not conduct any business.

COMMITTEE ON SCIENTIFIC ASSEMBLY

Mark M. Lindsey, M.D., Chairman

1978 Scientific Assembly: For the fourth successive year the MAG's Division of Education sponsored a fall Scientific Assembly. The 1978 Assembly, held November 11-14 at the Georgia World Congress Center in Atlanta, was a combined meeting of the MAG and the Southern Medical Association (SMA). In terms of both attendance and innovative cooperation between two major associations, it was highly successful. A total of 2,504 physicians attended the meeting; and, when students, nurses, allied health personnel, exhibitors, spouses, and guests are included, overall attendance was 4,255. There were 997 physician attendees from Georgia — the largest number from any state at an SMA meeting in this decade.

Special thanks go to E. Napier Burson Jr., M.D., of Atlanta, who served as General Chairman of the 1978 Assembly. Thanks also go to C. Rex Teeslink, M.D., of Augusta, who was MAG-SMA Program Coordinator, and to Edwin C. Evans, M.D., of Atlanta who 4 years ago conceived the idea of the combined meeting and who now serves as Chairman of the SMA Council.

All 23 of the major specialty societies in Georgia played an integral part in the planning and promotion of the scientific programs. Each society was represented by a program chairman who worked closely with the SMA section secretary on the program for the respective specialty.

Complementing the full schedule of scientific sessions were 17 well-attended postgraduate courses on a range of topics from gynecologic oncology to care of the multiply injured patient.

Delivering the annual Abner W. Calhoun Lecture at the MAG Luncheon on November 11 was C. H. William Ruhe, M.D., Senior Vice President of the AMA. He spoke on the topic "1984: Nightmare or Utopia for Medical Education?"

MAG's major financial responsibility for the 1978 Assembly was for publicity in the State of Georgia. A total of $10,000 was budgeted, and actual expenditures were $10,120.

Because of the success of the combined MAG-SMA Scientific Assembly, the committee would be receptive to holding another combined meeting when the SMA returns to Atlanta in the fall of 1982.

1979 Scientific Assembly: MAG's 1979 Scientific Assembly will be held November 15-18 at the Omni International Hotel in Atlanta. The 1979 Chairman is Mark M. Lindsey, M.D., of Atlanta. Nineteen specialty societies will be participating.

COMMITTEE ON TRANSFUSIONS AND TRANSPLANTATIONS

W. Frank Matthews, M.D., Chairman

There has been much sound and fury in the past year at the national level about transfusions. However, little, if any, productive work has emerged. It is the opinion of your committee chairman that regardless of the final form of American Blood Commission regulations, the State of Georgia will have little difficulty in implementing them. The Committee feels that most of Georgia, especially North Georgia, will meet any requirement for implementation of a regional transfusion service, but can do little until definitive regulations are received.

However, since no definite course of action has come from the national arena, there are no recommendations by your committee.

AUXILIARY TO THE MEDICAL ASSOCIATION OF GEORGIA

Mrs. Robert S. McMichael, President

Our Auxiliary year began with the orientation meeting for the incoming Executive Board at the annual convention last April. During this meeting we assessed the role of the Auxiliary in the community and determined that its response to the needs of others is the Auxiliary's most important factor. Our theme, "Light a Candle of Concern," was chosen to challenge all our members to devote their talents and time to the solution of problems of our society.

Early in the year the state president attended several meetings of the "Group on Health Education" at MAG. This group of health educators studied the problem of teenage pregnancy and judged it to be the number one health problem today. The Auxiliary joined forces with the group and made a good beginning in an awareness campaign throughout the state. Many county auxiliaries and health departments purchased the film "What Happened to Our Time?," task forces met on the county level, and speakers presented the multiple problems that arise from this central problem. This project will be continued next year.

The Georgia delegation to the national convention attended the sessions in St. Louis in June and then the Executive Board of AMAG met in Atlanta in July. During this 2-day meeting there were seminars concerning mental health, health projects, and teenage pregnancy.

In October, the state president, president-elect, and six county presidents-elect attended the Leadership Conference in Chicago. When the Executive Board met in Macon in January there were reports from this conference as well as reports from county presidents and discussions pertaining to membership, reports, and the use of the kit prepared for health education.

In February, the state president, president-elect, and legislative chairman attended the leadership training course in Chicago sponsored by the AMA.

The county auxiliaries have had a full year with work done in health projects pertaining to CPR, booster shots for immunization, visual and hearing screening in the schools, scholarships in health-related fields, and puppet shows designed to show the dangers of drugs.

One of the most pleasant aspects of the state president's job is visiting the county auxiliaries. It is a pleasure to see the accomplishments of the local auxiliaries and to enjoy the friendship of doctors' wives over the state. We can truly be proud of the more than 2,400 auxilians who have worked hard this year to lighten the many areas of shadows in their communities.

GEORGIA MEDICAL CARE FOUNDATION

Jack F. Menendez, M.D., President

During the past year, there have been a number of organizational changes among members of both the Board and staff. John G. Bates, M.D., was elected Vice-President, and Leonard C. Durrence Jr., M.D., was elected Secretary. Jack F. Menendez, M.D., continued in his capacity as President, and Michel A. Glucksman, M.D., continued in his capacity as Treasurer.

We were indeed saddened at the death of John R. McCain, M.D., on July 20, 1978. L. Newton Turk, M.D., was elevated to Director to replace Dr. McCain, and Charles E. Harrison, M.D., was elected to the position of Alternate Director.

D. R. Mahan Jr., M.D., found it necessary to resign his position as Medical Director, and I wish to extend my sincere appreciation for his contributions during his tenure. Richard A. Griffin III, M.D., was appointed as his replacement.

Among the changes in staff, Mr. Bill Minor resigned to assume duties outside of the state, and Mr. Don Solomon was hired to oversee financial and general administrative services. Mr. John Voigt resigned his position as Executive Secretary to pursue a course of study in law. I certainly wish to express my satisfaction with Mr. Voigt's services and to convey sincere appreciation for his efforts. Mr. Voigt was replaced by Mr. Robert Wesley who assumed his position on October 1, 1978.

During the year, the Foundation found it necessary due to PSRO requirements to formally sever its ties with the MAG and become a separate institution organizationally. A good, close working relationship will be maintained between the Foundation and the MAG, especially in that surveys we have conducted in the past have shown that PSRO functioning is far more efficient if such ties are maintained. An election of the Board will be held April 19-21, 1979, at the DeSoto Hilton in Savannah.

The Foundation found it necessary during the course of the year not to renew the subcontract for Medicaid review in the area previously designated as the Metropolitan Atlanta Foundation for Medical Care's (Metro Foundation) area. This was due primarily to insufficient funds being available in the Medicaid contract to cover the necessary operating costs of the Metro Foundation, especially in that assumption of the review process by the Georgia Medical Care Foundation resulted in significant cost savings. Subsequently, peer review of the Blue Cross and Blue Shield/Atlanta claims for outside the metro area was terminated by the Metro Foundation (the prime contractor) as insufficient monies to cover peer review costs were offered. The net result of this is that all claims requiring peer review for all areas serviced by Blue Cross and Blue Shield/Atlanta are now being reviewed by the Metro Foundation.

We continue to maintain three program departments in the Foundation, that of Hospital Services, Long Term Care Services, and Physician/Ambulatory Services. Although the PSRO project touches on all departments it is to be initiated first in the acute care hospitals. Ms. Lynn Myers, R.N., has ably led this project through its planning year and will be central to its implementation. A report on the planning year of the PSRO project follows as well as the individual department reports.

PSRO

The PSRO Program completed its planning year March 8, 1979, but for various reasons has had it extended. During the planning year, the PSRO was committed to accomplishing three goals: physician recruitment, amendment of the bylaws, and completing the formal plan as a grant application for conditional designation.

I. *Physician Recruitment*

The PSRO Medical Advisory Committee became quite

active during the planning year in the area of physician recruitment, and each of the members was invited to several medical staff meetings, local county medical societies, and various other meetings to publicize the PSRO Program and to recruit physician members. As a result of these recruitment efforts, the Foundation has 2,626 members on its rolls (approximately 35% of all licensed physicians in the state).

II. *Amendment of the Foundation's Bylaws*

The Georgia Medical Care Foundation's Board of Directors approved the modification of its bylaws on June 24, 1978. These amended bylaws were then ratified by the Medical Association of Georgia on December 12, 1978. These amended bylaws essentially separate the Foundation from the Medical Association of Georgia and established it as an independent corporation. Other bylaws changes were required by the PSRO regulations which mainly address the election of the Board members.

III. *Formal Plan*

The final draft of the formal plan for conditional designation was submitted to the Department of Health, Education, and Welfare (DHEW) on December 15, 1978, 15 days prior to the deadline. This plan has been approved by all participating agencies except the Department of Medical Assistance at this time.

The DMA and the Governor of the State of Georgia have recently requested that the Foundation have some degree of consumer participation on its Board of Directors. The DMA is also challenging some of the procedural aspects of the formal plan, and for these reasons, the Governor has not ''signed off'' on the formal plan. Until these issues are resolved it appears that the PSRO Program will be at a standstill in the planning stage, and additional contract funds will be required for this activity after May 1, 1979. This will, of course, delay the implementation of the PSRO Program by several months.

Hospital Services

1978 was a year of fluctuating volumes of claims review for the Department of Hospital Services. While the claims flow from Medicaid decreased drastically, the Foundation became more involved in reviewing appeals claims from Atlanta Blue Cross. Several other special projects were conducted by the Hospital Department during 1978 to replace the activities that had formerly been channeled into medical claims review.

During the calendar year of 1978, the Foundation received 948 Medicaid claims to review; 308 of these were referred to the Metropolitan Atlanta Foundation, and 640 were reviewed by the state Foundation. A total of 803 of these claims were approved, while 16 were reduced $91,302.00. All of the claims were appealed, and the reductions were partially overturned ($35,097.00). These data reflect the fact that the claims selected out for review were only those for $10,000 or over, and in general these claims represent quite acutely ill patients whose stays in the hospital were abnormally complicated and usually medically necessary.

The Hospital Department received 1,056 claims to review from Atlanta Blue Cross representing mostly Medicare but some private claims as well. Out of these 1,056 claims the Foundation reduced 3,583 days from these hospitalizations. At the average daily rate of hospitalization of $127.00, these 3,583 days might represent a savings to Blue Cross of $455,041.00.

To expedite the review process, the Foundation instituted a new review procedure which requires the hospital to send a discharge summary for every claim over $10,000 to the Foundation. For the most part this eliminated the need for additional medical records because the discharge summaries reflected what transpired during the hospitalization. Also, the Foundation has coordinated its activities with the DMA to the point where we are now communicating directly with the hospitals regarding negative recommendations which we forward to the DMA. In the past, these negative recommendations have been channeled through DMA, and much confusion resulted. The hospitals may now communicate directly with the Foundation, which is the source of the negative recommendations.

Long-Term Care Services

As in previous years, nursing home programs comprise the bulk of long-term care services activities, and the growth pattern continues to be evident. Program activities include semi-annual reviews of a total of three hundred and six (306) nursing home facilities in the State of Georgia and involve review of care for approximately twenty four thousand five hundred patients (24,500) each review.

The reviews are conducted by 12 teams located throughout the state with physician support from the local area. A team consists of a physician, a registered nurse, and a social worker. Approximately one-third (⅓) of all patients reviewed are either psychiatrically disabled or mentally retarded with a history of placement in a state institution. There has been an increase of approximately 1,000 residents in nursing homes in the past 12 months. These teams perform utilization review and Medicaid review in all skilled nursing homes in the State of Georgia and independent professional review in all intermediate care and intermediate care/mental retardation centers. Medical care evaluation studies are conducted on all skilled patients and the results are made available to the nursing homes for in-service, educational, and other purposes.

Telephone precertification of nursing home residents (now a requirement for placement) experienced notable growth in the past 12-month period, with a total of nearly ten thousand (10,000) precertifications for placement being processed. All health provider agencies have access to this service by calling the toll-free WATS line number, 1-800-282-4575.

The Nursing Home Bed Registry was developed to assist health care personnel in their efforts to locate the closest available nursing home bed vacancy at the appropriate level of care for patients requiring placement. During this initial year of operation, approximately three thousand (3,000) calls were received on the special WATS line number (1-800-282-4573) from locations throughout the state.

The Home Health Care review program provides for utilization review of Medicaid patients receiving home-delivered health care. Record reviews are conducted three times a year, and approximately 20% of the patients are visited in their homes during the course of the year. Since the initiation of this program, the number of Home Health Agencies providing care to Medicaid recipients in the

State of Georgia has grown from 14 to 31. Currently, there are approximately seven hundred (700) patients being reviewed each review period.

An additional program, the Alternative Health Service review, was developed during the past year. This program was established to monitor and evaluate services provided to clients receiving an expanded range of health and social services in the community setting through the Alternative Health Service Project. This is an experimental program available in 17 counties surrounding Atlanta and Athens, Georgia, which provides services for Medicaid clients who are eligible for nursing home placement. Available services include: 1) traditional home-delivered health care with additional options of home-delivered meals, homemaker services, and transportation for medical services, 2) adult day rehabilitation centers (offering part-time custodial care and medical supervision), and 3) alternative living services (structured, supervised living environment). The review process for this program includes record reviews of all clients three times a year, and home visits for 50% of the clients during the course of the year. Approximately six hundred (600) clients are reviewed each review period.

The 10-member Long Term Care Specialty Panel has met monthly to discuss policy, criteria, and patient review. A panel visit was made to the Georgia Retardation Center as a prelude to the development of ICF-MR placement criteria.

This department has again successfully passed DHEW operational requirements for continuation of the utilization review waiver as well as an operational on-site and in-house review audit. This places the DMA in total compliance with the DHEW requirements for Long Term Care review.

Physician/Ambulatory Services

The Foundation functions with 14 Specialty Panels which include medical and surgical specialties, as well as podiatry and psychology. The Foundation also utilizes the services of approximately 600 consultants to review claims.

In the first 3 months of 1978, the Physician Service Department reviewed a total of 10,560 physician Medicaid claims. Since that time, the Foundation has reviewed only patterns of practice, along with a few special individual reviews. The patterns are of randomly selected physicians, and are comprised of all of the claims submitted by those physicians in the years 1977 and/or 1978. These patterns represent approximately 35,000 claims. The patterns are reviewed by consultants of the same specialty as the providing physician, and review decisions are made by the appropriate panels.

Medicaid has proposed that the Foundation would review claims via a computerized system. This review has not yet materialized.

At the request of the Podiatry Panel, a new system of comprehensive podiatric review is being worked out with the use of the Medicaid computer.

The Foundation *Guidelines for Use in Peer Review* have been undergoing revision by all the panels. This has been an involved undertaking, but updating and revision are thought to be essential in order to stay current with present medical thinking.

Throughout the year 1978, the Foundation received 709 commercial physician claims for review. These included 58 CHAMPUS claims in the first 4 months of the year. Since CHAMPUS' move to Omaha, we have received no further CHAMPUS claims for review. The Foundation signed two new commercial contracts during the year 1978, one with Prudential-Medicare and the other with Blue Shield/Columbus, the latter having been renewed in January 1979. The Blue Shield/Columbus contract is intended to provide means of appeal for physician claims while the Prudential contract involves both individual physician claims and patterns of practice. Physician claims and patterns of practice received under these contracts has been negligible.

Commercial review has declined in the past few months since the review for Blue Shield-Blue Cross/Atlanta has been taken over by the Metropolitan Atlanta Foundation for Medical Care.

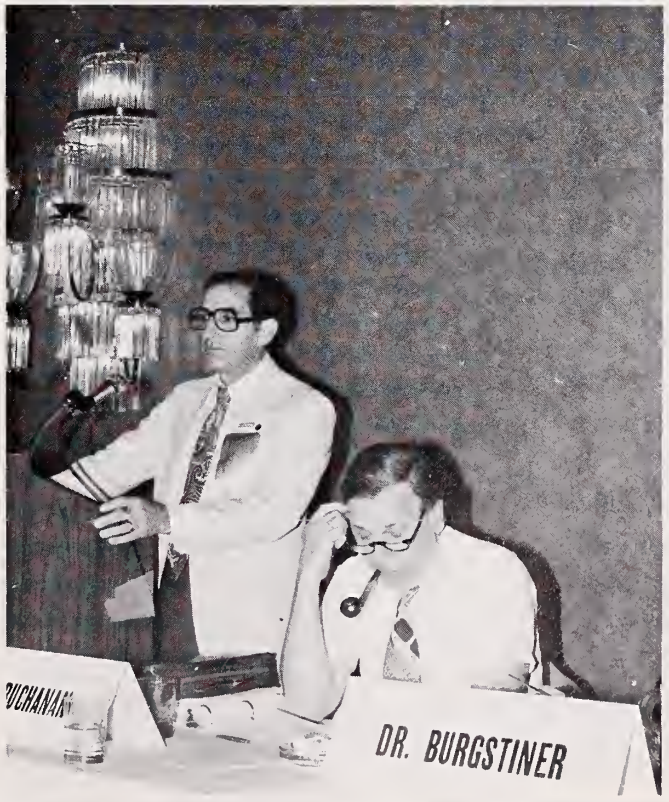
Efforts continue to maintain a dialogue with both Medicaid and the private insurance companies in the hope of expanding the review process.

Administration

In addition to the staff changes mentioned in the opening paragraph of this report, considerable reorganization was accomplished in the administrative offices which yielded significant improvements in the efficiency of the operation. They also resulted in reduced administrative costs in spite of general increases in the rate of inflation. A fairly extensive employee orientation and training program is being initiated in order that we may be even more efficient.

The DMA completed a financial audit of our operations, and were quite satisfied with our accounting methodologies. The Foundation in general is in excellent financial condition.

I shall be happy to answer any questions that you might have concerning the Foundation at any time that is convenient.



Vice-Speaker Jack F. Menendez (left) conducts House business, while Speaker L. C. Buchanan ponders the issues.

JOURNAL OF THE MEDICAL ASSOCIATION OF GEORGIA

Edgar Woody Jr., M.D., Editor

Content

During the year 1978-79, we have made a concerted effort to present and keep our members abreast of current issues relating to the delivery of quality medical care. High on our list of priorities have been better approaches to cost control both at the hospital and office practice levels. Special issues have featured the Medical College of Georgia, the Georgia Heart Association, and teenage pregnancy.

Credits

Our contributing editors continue to be very helpful in the solicitation and review of scientific material for publication. The Executive Committee of our Board of Directors, which also functions as the Publications Committee of the *Journal,* continues to serve in its vital role as the final arbiter in matters of *Journal* policy. The Georgia Chapter of the American Cancer Society and the Georgia Heart Association have maintained their usual high standards in the screening of quality material for their respective specialty pages.

Richard Vincent, our able MAG legal counsel, along with his staff, have supplied the *Journal* with excellent and timely material for our legal page.

Our cover artists over the past year, Richard Lyons, Bob Hamill, and John McKenzie, have produced some very attractive illustrations which have enhanced the appearance of the publication.

The fine contributions and helpful advice given by the members of the headquarters office staff should be pointed out. Without their continuing input, the *Journal* could not adequately reflect the numerous activities of the Association.

Dr. J. G. McDaniel continues to guide his entertaining feature page, "I've Told This Before" in the right direction. This often quoted feature encourages contributions of original anecdotes from all interested members. The President's Letter has maintained consistent quality and timeliness throughout the year.



Solomons Pharmacy, a familiar Savannah landmark, as seen from the pool terrace of the DeSoto Hilton.

State Medical Journal Advertising Bureau

Our sales organization operating out of Chicago for national pharmaceutical advertising has averaged a 10 to 12% increase in revenues each year for the past 2 years. This is remarkable in view of the fact that the trends were downward before the hiring of a new sales force from Williams and Wilkins 2 years ago. Your editor is fortunate to have served as a member of the Board of Directors of the Bureau for the past several years.

Personnel

In September of 1978, Susan J. Dillon joined the MAG staff as Managing Editor of the *Journal,* replacing Sharon T. Smith who had held the position for almost 2 years.

A native of Arizona, Ms. Dillon attended Duke University and the University of Nottingham in England. She completed her undergraduate studies at the University of Texas where she received a Bachelor of Arts degree in English. Prior to joining the *Journal* she had extensive experience in writing and editing as a member of the staff of the Center for Disease Control in Atlanta. The impact of her editing skill is already reflected in the pages of the *Journal.*

Local Advertising

Our well-organized local advertising sales force is continuing to move forward. Our sales representative, Ms. Mary Coté, is doing an excellent job and would welcome any leads or suggestions from our members which may lead her to potential advertisers.

MAG SERVICES, INC.

J. Rhodes Haverty, M.D., President

As president of MAG Services, Inc., I am pleased to offer the following report on the activities of the printshop 1978-79.

Our printshop continues to function well, and our volume of business has increased quite noticeably. We have added quite a number of new customers during the past year and also have increased our repeat business from the members which we have been serving by way of letterhead, stationery, prescription pads, etc. While we are not completely out of the financial woods at the time of this report, our books are looking better and better each day.

During the past few months, we have added the newsletter of the Joint Board of Family Practice, which we print quarterly for them. In April, we will start to print the newsletter for the Georgia Academy of Family Physicians. We continue to print the *Newsletter* for the MAG and various other publications for MAG, in addition to MAG's Research and Development Department, the Georgia Medical Care Foundation, and GaMPAC.

This year, you will be pleased to know that we printed the membership directory for the Auxiliary to the MAG and have already been contacted by the Auxiliary to print their 1979-80 directory.

Because of our increased volume, we have added a second press to our printshop, which enables us to speed up our production time and give a speedier service to customers.

We invite each of you who may not now be using our services to give us a try, as our prices are quite competitive with other printshops all across the state, and in 99% of cases, are well under any commercial printshop which we have surveyed. We stand ready, willing, and able to give each of you reasonable, courteous, and prompt service at all times.

For those of you who currently use our services, we sincerely hope that you are well satisfied with them and may we look forward to having you as a valued customer for many years to come.

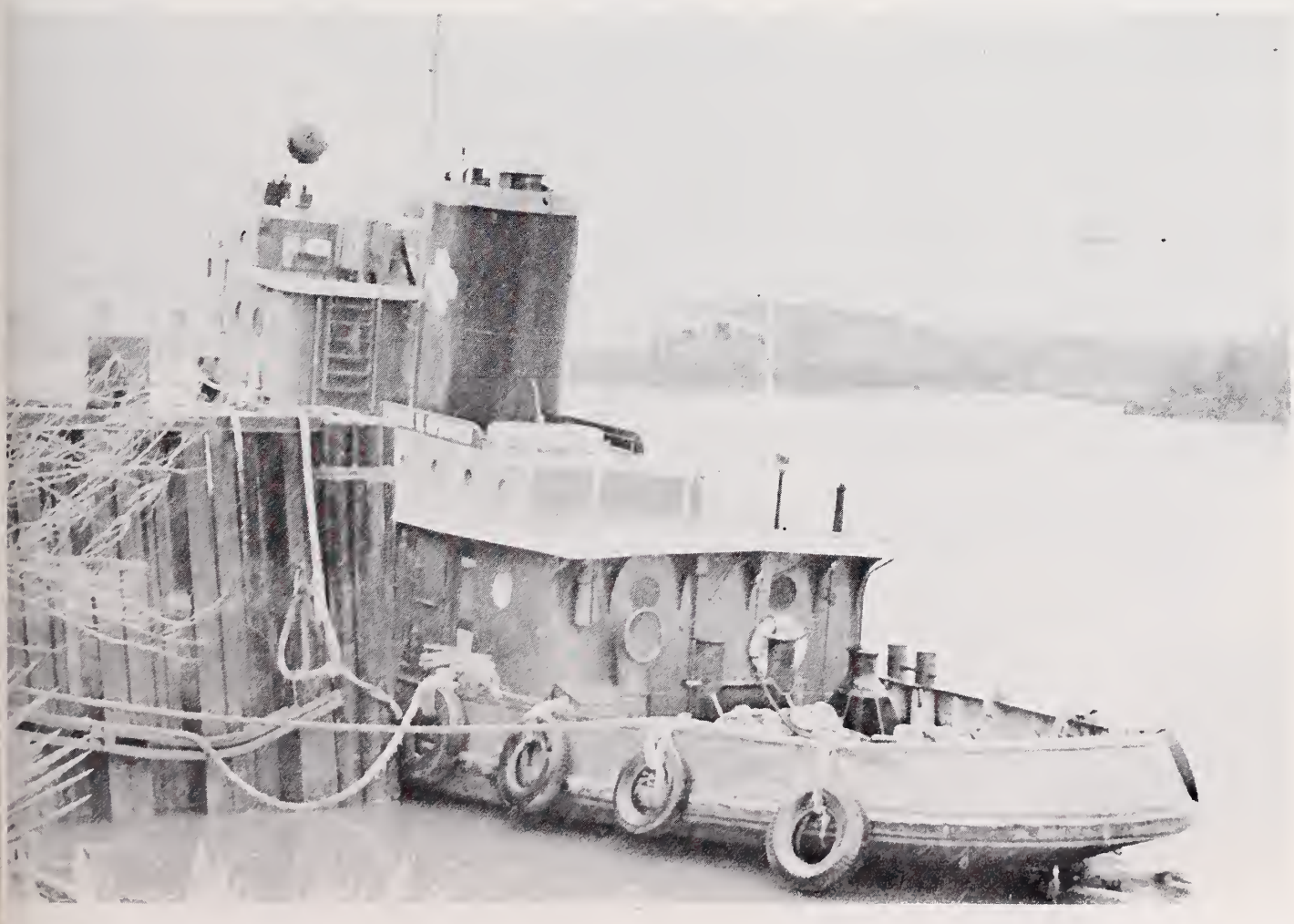
NEW BUSINESS

The Speaker proceeded to new business, calling for the introduction of resolutions.

(R1) Second Opinions Mandated by Third Party Payors
(R2) Chiropractic Practices
(R3) Funding for Health Systems Agencies
(R4) Blue Shield Funding of MCG Program for Cost Containment
(R5) County Coroner System
(R6) Medicaid Providers
(R7) MAG Public Relations Program
(R8) Geographical Fee Determination
(R9) MAA Cost Accountability Report
(R10) Hospital Patient Records
(R11) Right to Die, S.B. 86, H.B. 30
(R12) Statement on Specific Therapeutic Modalities
(R13) Catastrophic Medical Insurance
(R14) Legal Age for Purchase of Alcohol
(R15) State of Georgia Department of Human Resources
(R16) Peer Review/PSRO
(R17) PSRO National Budget
(R18) Hospital Satellite Clinics
(R19) Commend Charles Todd, M.D.
(R20) Private Treatment of Medicaid and Indigent Patients

At this point, Dr. Louis Felder spoke briefly to the House of Delegates in reference to support of an effort to secure passage of a constitutional amendment that would limit federal spending to federal incomes.

Following brief announcements made by the Speaker, the First Session of the House of Delegates was adjourned at 12:05 p.m.



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Second Session, House of Delegates
Saturday, April 21

THE SECOND SESSION of the House of Delegates of the Medical Association of Georgia Annual Session Business Meeting was called to order at 10:05 a.m. on Saturday, April 21, 1979, in the ballroom of the DeSoto Hilton Hotel, Savannah, Georgia, by Speaker L. C. Buchanan, Decatur.

Speaker Buchanan then recognized LaMar McGinnis, M.D., and John Heard, M.D., for the purpose of presenting Michael Mescon, Ph.D., who spoke briefly to the House of Delegates on the matter of the seminar on Private Enterprise Perspectives of medicine to be held in Atlanta May 26-27, 1979.

The Speaker asked for a report on attendance from Edwin C. Evans, M.D., reporting for the Credentials Committee, and it was reported that 177 duly elected delegates, representing 47 component county medical societies were present for the second session and, accordingly, a quorum did exist.

Reference Committee Reports

Speaker Buchanan called for reports from the Reference Committee chairmen. The Speaker restated the procedure that would be followed and then proceeded to call for reports from Reference Committees in the following order: Reference Committee A, Reference Committee E, Reference Committee D, and Reference Committee C.



John P. Heard, M.D. (left), from Decatur introduces Michael Mescon, Ph.D., from Georgia State University who spoke about the PEP Seminar in Atlanta. MAG staffers Lola Inman Brown and Mr. James M. Moffett look and listen. Speaker Buchanan is at the podium.

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Henry Evans, M.D., Clinical Director
William C. Greer, M.D.
David V. MacNaughton, M.D.
John S. McDougal, M.D.
Robert T. Spaulding, M.D., F.A.P.A., Medical Director

Internal Medicine Consultant
Charles D. Kennedy, M.D.

Clinical Psychology
Thomas L. Cory, Ph.D.
Jerry C. Gilliland, Ph.D.
Ann Morris, M.S.
Bobby G. Rouse, Ph.D.
Roy Smith, Ph.D.

Adjunctive Therapy
Dan B. Page, M.Ed.

Administrator
Dennis P. Dobard

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(Left photo): Dr. H. Duane Blair presents report of Reference Committee A to the Second Session of the House, while Dr. Carson Burgstiner reviews a copy. (Right photo): Members of Reference Committee A listen to discussion about disabled doctors program. Shown are (L-R) Ken Williams, MAG staff, Dr. H. Duane Blair, and Dr. Arthur Merrill Jr.

Report of Reference Committee A

H. DUANE BLAIR, M.D., Chairman
RONALD F. GALLOWAY, M.D., Vice-Chairman

Chairman Blair reported to the House of Delegates that the reports and resolutions referred to Reference Committee A, which met in the Center Ballroom, DeSoto Hilton Hotel, Savannah, Georgia, on April 20, 1979, were carefully considered. The members of the Reference Committee were: H. Duane Blair, M.D., Chairman; Ronald F. Galloway, M.D., Vice-Chairman; Joe L. Nettles, M.D., Savannah; Charles R. Richardson, M.D., Statesboro; David Frolich, M.D., Macon; Arthur J. Merrill Jr., M.D., Atlanta.

PHYSICIANS' CONSULTANT COMMITTEE TO THE DISABLED DOCTORS PROGRAM

G. Douglas Talbott, M.D., Chairman

In 1978-79 the MAG's Disabled Doctors Program has had substantial growth and development. Experientially maturing, the staff of the Program has developed expertise in dealing with the impaired physician. The following data demonstrates this.

The term "MAG's New Medical School" has been aptly used to describe the 77 physicians who have now been returned to a successful, sober, productive, and happy practice. These physicians would have been a deficit to medicine if it had not been for the Disabled Doctors Program. In truth, they represent the enrollment of a small medical school class.

Pertinent developmental components of the current MAG's Disabled Doctors Program are described.

Organizational Development

As the Program has developed and grown, the organization of the staff and components of the Program have become more sophisticated. The enclosed chart of the table of organization demonstrates the current operating organizational structure of the Program. The Treatment and Management Team meets regularly every 2-3 weeks and continues the critical basic management role on a daily basis of the disabled doctors who are in treatment. The relationship of this Committee to the rest of the Committees are shown in the organizational chart.

In addition, as the Program has grown to its present size, subcommittees reporting to the Physicians Consultant Committee have been formulated and instrumented. These subcommittees for dealing with reeducation, confrontation, placement, and reentry, as well as identification and verification, are listed below. These subcommittees are currently in the process of either training or implementation.

Identification and Verification
Motivation and Confrontation
Reassessment, Reeducation, and Placement
Reentry and Follow-up

Caduceus Club

Every Tuesday night the Caduceus Club meets. For 1 hour the wives convene with an educational and training therapist, while the doctors in practice and the doctors in treatment meet in two other groups. Both of these groups are under trained therapists.

In addition, two weekend retreats permit and encourage the disabled doctors to join in a resocialization and training experience. In February 1979 at Cohutta Lodge in Chatsworth, Georgia, 75 physicians and their spouses met for an educational training and social experience.

These 1½ hour Tuesday night training and educational programs for the spouses, physicians in treatment, and physicians back in practice have proved an invaluable adjunct to recovery. Under the experienced leadership of our senior staff therapists, the mutual problems of the disabled doctors, their marriages, their jobs, their reentry into practice are discussed and examined. It is anticipated that a family discussion group will be added this summer recognizing this disorder as a family disease and the

importance of having the couples mutually discuss their problems.

Medical School Activities

Both Emory University Medical School in Atlanta and the Medical College of Georgia in Augusta have acknowledged and recognized the valuable prophylactic contribution that the MAG's Program and the Disabled Doctors Program can contribute to the curriculum of the medical school.

Meetings with the freshmen, sophomore, and junior medical students at both schools are held with volunteer disabled doctors. A seminar entitled, "It Couldn't Happen to Me" is presented by these physicians who share their disease history and their recovery. They present an unusual insight into the dynamics of the disease of chemical dependency to the medical students. The enthusiasm of the medical students for these seminars have been overwhelming and represent a substantial preventive effort by the MAG for the problem of chemical dependency in physicians.

Budgetary Consideration

It is proposed that although the MAG's Disabled Doctors Program has doubled in size, that the budgetary requirements and requests will be less than last year. This has been influenced by the acquisition of Federal Vocational Rehabilitation funds to the Program for disabled doctors in treatment. These funds have allowed us to add another group leader for the educational and training sessions to help with the couples and marriage problems in our disabled doctors. Even with the addition of this educational and training leader in couples and marriage therapy, we have been able to reduce the total budgetary request from last year from the MAG. The salaried positions and request in this area are stable, although both the Medical Director and the Auxiliary Program Coordinator as well as the Administrative Secretary are literally putting in hundreds of hours of overtime and weekend efforts.

It is also imperative to note that Ridgeview Institute which has donated space for the headquarters of the Disabled Doctors Program has as of this date provided in excess of $100,000 of free and donated medical services, beds, and staffing care for the disabled doctors in the Georgia Program. The Administrative Director of Ridgeview Institute and the Board of Trustees have been willing to make this contribution in view of the quality of the MAG Program and the contribution it is making at the national level. It is recognized that the MAG's Disabled Doctors Program has assumed national leadership in the United States as well as Canada in the treatment of disabled doctors.

The contingency fund continues to function in such emergency situations in which disabled doctors have had to rent apartments for a short period of time when the disabled doctors' halfway houses have become filled to capacity, when disabled doctors have had no money and required travel funds, when the purchase of clothes for impaired physicians have been necessary due to either lack of funds or frozen assets, or when money is not available because of such legal problems as divorce and bankruptcy. In addition, the contingency fund has been used for hospitalization costs for some physicians in which no funding was available.

Medical Association of Georgia
Disabled Doctors Program
Statistical Data – February 1, 1979

Contacted and Verified	155
Entered Treatment	118
Returned to Practice	77
Currently in Treatment	23
Repeating Treatment	11
Broken Contracts	12
Deceased	3

RECOMMENDATION

Although the Committee made no recommendations, the Board felt the Report was of such significance that it should be referred.

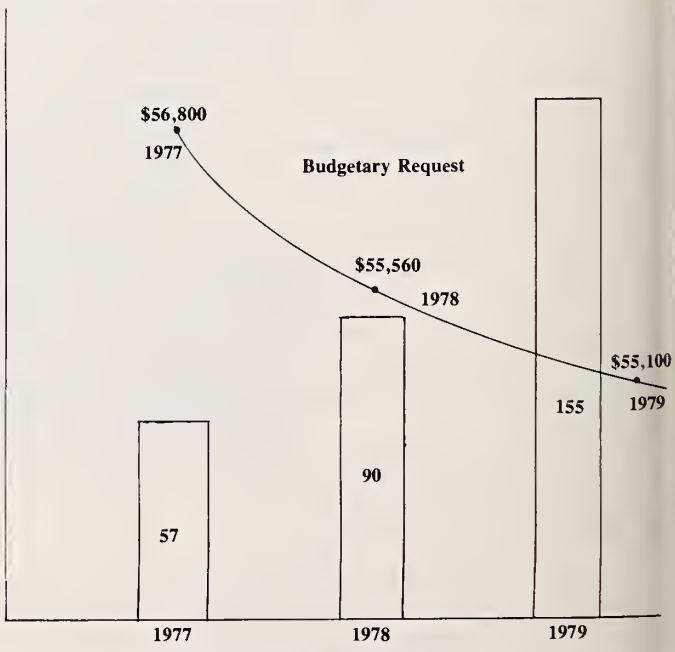
REFERENCE COMMITTEE DISCUSSION

The Report is testimony of the tremendous success of the Committee's work and the fine leadership of G. Douglas Talbott, M.D., Chairman of the Committee.

RECOMMENDATION

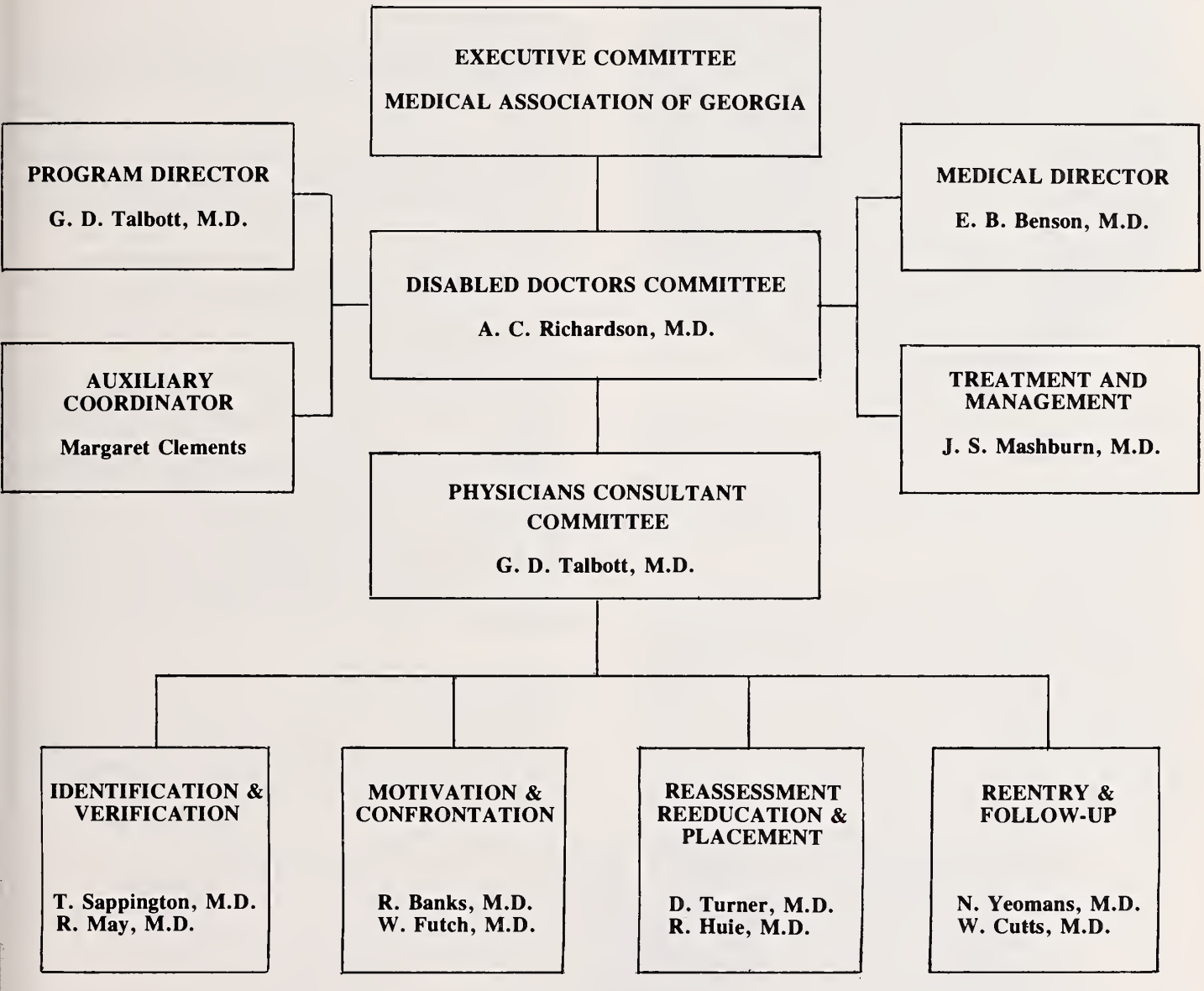
Mr. Speaker, your Reference Committee wishes to commend the Physicians' Consultant Committee to the Disabled Doctors Program and advises the House that such commendation be forwarded to the Committee by the House.

HOUSE OF DELEGATES ACTION — The House expressed no opposition to the recommendations.



Physician Involvement in MAG's Disabled Doctors Program

MEDICAL ASSOCIATION OF GEORGIA DISABLED DOCTORS PROGRAM



COMMITTEE ON PROFESSIONAL CONDUCT AND MEDICAL ETHICS

A Cullen Richardson Jr., M.D., Chairman

During the past year, there have been approximately 150 complaints which have come to the attention of this Committee. As mandated in our Constitution and Bylaws, most of these were referred back to the local medical societies for action. Those complaints which concerned physicians who are not members of the MAG were forwarded directly to the Composite State Board of Medical Examiners.

MAG staff under the direction of the chairman has been able to handle most of the complaints. A summary of complaints and actions taken was routinely sent by staff to each committee member.

The full committee has met on three separate occasions during the past year, all of which were combined meetings with the Disabled Doctors Committee.

To date, the two most frequent complaints which come to our attention are (1) patients not being able to get a copy of their medical records, and (2) being charged an admission fee to be admitted to the hospital. We have been able to handle most of the complaints which have come to us, but there were several that we were not able to adjudicate. A major problem is that we are usually unable to find out

the final action taken on those forwarded to a county medical society.

Because of some of the currently existing problems and pending Federal Trade Commission (FTC) litigation, your Committee is of the opinion that the MAG should strongly consider establishing a Judicial Council which would augment, but not necessarily supplant, the Professional Conduct and Medical Ethics Committee.

The Judicial Council should rule on all ethical pronouncements. It should have the power to censor, suspend, expel, or to take other such disciplinary action with respect to members it may deem proper under the circumstances.

It is felt that because of the present appellate mechanism as defined in the MAG Constitution and Bylaws, giving the Board the authority to hear and adjudicate cases which it may or may not have heard could cause MAG serious legal problems in the future, especially if the FTC has its way and prevails in the suit which it has filed against the AMA and various other state and county medical societies.

It would appear that the Constitution and Bylaws of the MAG should be changed to establish a separate and distinct Judicial Council, being completely separate from the legislative body, which is the House of Delegates, and the executive body, which is the Board of Directors. I suggest the following:

RECOMMENDATIONS

1. That the MAG amend its Constitution and Bylaws, establishing a separate and distinct Judicial Council.
2. That the Judicial Council be truly a "blue ribbon" group. It could be composed of the three to five most recent past presidents.
3. That the Judicial Council be given the power to censor, suspend, expel, or to take such other disciplinary action with respect to members or component societies.
4. That the MAG's Committee on Constitution and Bylaws be directed to draw up the necessary amendments to the Constitution and Bylaws paying particular attention to due process and the appeals mechanism and presenting that language to the 1980 MAG House of Delegates for its consideration.

REFERENCE COMMITTEE DISCUSSION

The Committee on Professional Conduct and Medical Ethics asks that MAG amend its Constitution and Bylaws to establish a separate and distinct Judicial Council. The proposed Judicial Council would not take away from the Committee on Professional Conduct and Medical Ethics the routine day-to-day problems and complaints but would serve as a higher court and, in addition, issue ethical pronouncements.

The proposed Judicial Council would be given the power to censor, suspend, expel, or to take such other disciplinary action with respect to members or component societies.

The AMA has recommended a separate Judicial Council which would pose fewer problems with the FTC.

The Committee on Professional Conduct and Medical Ethics asks that the Constitution and Bylaws Committee be directed to draw up the necessary amendments, paying particular attention to due process and the appeals mechanism, and present that language to the 1980 House of Delegates for its consideration.

RECOMMENDATION

Mr. Speaker, your reference committee, based on testimony given before the Committee, believes that a Judicial Council could cause massive restructuring of MAG's Constitution and Bylaws. Such a Judicial



Delegate Dan Bateman expresses his viewpoint at Reference Committee A's meeting.

Council would also consolidate judicial powers within the hands of a few individuals and, according to legal counsel, would not minimize any problems our current Professional Conduct and Medical Ethics Committee structure may pose with respect to the FTC. Your reference committee also wishes to point out that disciplinary actions would not basically change from the now existing structure. Your reference committee advises that the recommendations of the Professional Conduct and Medical Ethics Committee be not adopted.

HOUSE OF DELEGATES ACTION — Voted to not adopt the recommendations of the Report of the Committee on Professional Conduct and Medical Ethics.

THIRD PARTY RELATIONS

Charles D. Hollis Jr., M.D., Chairman

The Committee on Third Party Relations met twice with good attendance by its members. Attending the meetings to provide information and to serve as consultants have been representatives from Medicare, including Mr. Douglass Richard, Southeastern Director for Medicare, and Mr. Jim Willis, State Director of Medicare, Mr. David Poythress, Commissioner of the Department of Medical Assistance, Mr. Matt Thomason from the Prudential Insurance Company, Mr. Ted Snyder of Prudential (Medicare), and representatives from the Atlanta and Columbus Blue Cross/Blue Shield plans.

The primary charge of the committee by the House of Delegates this year was to pursue the possibility of establishing a statewide payment schedule under Medicare-Medicaid, after obtaining a survey to see what effect this would have on fees in the various metropolitan and rural areas in the state. This and other matters discussed by the committee are summarized below.

STATEWIDE PAYMENT SCHEDULE UNDER MEDICARE-MEDICAID

MEDICARE

Following a special request from Senator Talmadge's office, HEW agreed to conduct a survey of fee patterns throughout the state, using a very complex methodology labeled "SAW II." Under this "SAW II" statistical study, seven different patterns of charges were identified in Georgia. The charges were analyzed on the basis of county, specialty, and procedure for each physician. The results of the study indicate that a majority of fees charged fall in a median group in which payment would be unchanged in a statewide allowance. A smaller percentage of fees fall below the median and would have to be increased somewhat to establish a single schedule, while some fees would fall above the median and would have to be decreased to the median. The complicating element is that the analysis is done by procedure, and the same physician would notice some modification of his allowances, both up and down, depending on the procedure.



Dr. Charles Hollis Jr. speaking before Reference Committee A.

HEW regulations would require a complete modification of profiles of every physician. Representatives of Medicare in the Southeastern area, who expressed sympathy for our goal of establishing equity in payment schedules, expressed the personal opinion that it was almost impossible under the present law to correct inequities and that the only realistic approach to accomplish our objectives would be to work for a change in the law. Several other comments were made. The Secretary of HEW, Mr. Califano, has proposed that statewide fees be negotiated, and there is strong sentiment in the Subcommittee on Health of the Senate Finance Committee to proceed along this same line. Statewide fees could be negotiated during the upcoming fiscal year. It was also pointed out that if the MAG requested a change to a statewide schedule based on "SAW II," and if HEW accepted this request, a changeover would require about 2 years for implementation.

It was estimated that if all physicians continued to charge their usual fee, regardless of their present fee profile, the method of upgrading fees according to the economic index would equalize fees in about 4 to 5 years.

After prolonged discussion and consultation during the two meetings, the Committee on Third Party Relations voted to recommend to the House of Delegates that nothing further be done at the present time toward requesting HEW to make a change in their payment schedules.

MEDICAID

Mr. David Poythress attended both meetings and informed the Committee about problems and progress he is experiencing in managing the Medicaid program for Georgia.

Mr. Poythress has requested HEW to allow him to initiate a pilot project of paying negotiated fees on a

statewide basis. After considerable correspondence and a trip to Washington, Mr. Poythress was informed that even a pilot project of this sort is not permissible under the present law.

Medicaid has reduced the time required to process claims to less than 18 days. Magnetic tape tie-in procedures for submitting claims have been established in several areas of the state, primarily for hospitals and pharmacists, and this has proved to be extremely effective in reducing errors and processing time. Mr. Poythress stated that it would be highly desirable for groups of physicians or perhaps county medical societies to use cooperatively a computer terminal and operator for submission of claims data. It would eliminate a great deal of paperwork and would reduce the time required to make payment. Medicare and the Blue Cross/Blue Shield plan of Columbus are in the process of developing the capability of receiving claims data by tape-to-tape contact. Florida, which has been doing this for some time, is processing claims in 2 days.

Mr. Poythress and Mr. Tom Olmer reported on a methodology being developed in Georgia to meet the "prudent buyer" concept as now required by the Health Care Financing Administration. A very innovative program is being designed which might set the pattern for the entire country. Hospitals will be grouped and hospital admissions will be categorized into some 83 diagnosis-related groups. In this way, similar hospitals can be compared in the cost of handling patients with similar types of illnesses. A yearly adjustment would be made between costs and charges, and a percentage of the highest charges for similar services would be disallowed. There would also be an inducement to improve efficiency by giving supplements to those hospitals falling below the median cost for similar services.

Mr. Poythress and Mr. Olmer reported the present status of their studies to the Board of Directors and will keep the MAG informed about further implementation of the prudent buyer concept.

Mr. Poythress then discussed a request from the radiologists of the state to extend the 3-month limit for filing claims after the service has been rendered. He felt that it was absolutely necessary to maintain the 3-month rule in order to do realistic budget planning. He felt that if physicians' groups re-studied their way of identifying the agencies responsible for payment of patients' charges, that something could be worked out to make possible compliance with the 90-day rule.

Medicaid is now attempting to facilitate the physician's bookkeeping by notifying him at the time of payment of each claim the amount of the claim paid, the amount rejected, and the amount still in process. By analyzing these three bits of information, it will be possible for the physician to keep his accounts receivable in balance. This should be a considerable help to the physician in his bookkeeping of Medicaid charges and payments.

Mr. Poythress commented on the report by Congressman Moss of the House Subcommittee on Investigations and Oversight of the Interstate and Foreign Commerce Committee, which criticized Medicaid programs in the country. Mr. Poythress felt that the Moss Report on unnecessary surgery represented unfair criticism, since each Medicaid program was asked to submit data in the matter of a few days when the committee had had the matter under advisement for a year or two. He pointed out that the Georgia Medicaid program did have the data necessary to meet the criticism of the Moss Report but simply was not given time to accumulate it and forward it to the committee.

When a physician needs to make an inquiry about a claim he has submitted he should call the INQUIRY UNIT. By submitting either the patient number or the physician number the claim can be immediately traced down and the physician's question can be answered. The INQUIRY UNIT can be contacted by calling the following number: (404) 894-4940.

The Committee on Third Party Relations expressed a consensus that although there are still many problems remaining in the Medicaid program, Mr. Poythress has done an excellent job of improving the situation and that his future plans for upgrading services both to the public and to the physician seem quite constructive. The Committee felt that he should be commended for the job he is doing.

SECOND OPINION PROGRAMS

Mr. Matt Thomason of the Prudential Insurance Company commented on the information that Prudential intended to include second opinion requirements in its policies, penalizing a patient not obtaining a second opinion, and utilizing a closed panel of consultants for that second opinion. Mr. Thomason stated at the November meeting that even though there is considerable discussion at the present time, none of these policies is being sold in Georgia. He stated that data over the country indicate that information is still incomplete as to the savings and that the tendency now will be to proceed slowly since cost-benefits have not been identified. Studies conducted in states which already have voluntary second opinion programs show that the programs are not highly accepted by patients. In Pennsylvania, for instance, only 3% of the eligible participants sought a second opinion. The voluntary program is also available under Medicare, but very few patients have availed themselves of this option. Information from Blue Cross/Blue Shield representatives also indicate that the third parties in general are proceeding slowly in requiring second opinions because of the questionable savings. It was pointed out that most Blue Shield plans, as well as Medicare, already offer a voluntary second opinion option to the patient.

BLUE CROSS/BLUE SHIELD

The representatives of Blue Cross/Blue Shield discussed the recent "Medical Necessity Project" in which the national office recommended that some 28 procedures no longer be considered useful or valid and should therefore not be paid by the Blues.

In the Atlanta area, this was analyzed over a short

period of time, and 400 occurrences of the 28 procedures were identified. Procedures were still paid for, but were referred to the Foundation for consideration. The Foundation recommended that five procedures no longer be reimbursed, including such things as basal metabolic rate and the protein bound iodine. At this time the matter is under further study by the local Blues. There will be no retroactive denials. After further study the physicians and the hospitals will be advised about any new policy adopted.

The local Blues Plans will also study the use of "Standing Orders." The matter will be approached initially as an educational exercise. After information has been accumulated, it will be presented to the Boards of Directors for consideration and advice. There is general feeling at this time that a recommendation will be made that admission battery tests should be disallowed and only procedures that are ordered specifically by a physician should be paid. The MAG Cost Accountability Committee apparently is also studying this matter.

The Committee on Third Party Relations recommends to the MAG that it establish the policy that all tests on hospital patients should be ordered by physicians except those required by state law. All routine hospital admission testing should be eliminated.

CURRENT PROCEDURAL TERMINOLOGY — FOURTH EDITION (CPT-IV)

Updated information on policy regarding coding was received from the various third party carriers. It is now apparent that the CPT-IV will become the universal service code for all carriers throughout the country. Medicaid has been utilizing this code for some time. Prudential (Medicare) now encourages all physicians to code their services with the 5-digit CPT-IV code and will begin workshops in April to teach and encourage physicians to code their services by this method. With the use of these numbers it will not be necessary to include any written description of the services. Blue Shield of Columbus voted at its February 1979 meeting to convert to use of the CPT-IV code. The conversion by Blue Shield will be a gradual process and will require about 2 years before final implementation and payments will be made by this method. Blue Shield of Atlanta has not yet made a decision on a changeover to CPT-IV.

In the discussions it was pointed out that less than one fourth of physicians in Georgia use any code to describe their services. Again, the Committee on Third Party Relations encourages members of the MAG to use the CPT-IV code for identification of services for all third party carriers. It is a more precise way of defining the service rendered and will speed up claims processing, assuring that the physician will receive a more appropriate payment in a shorter time.

It was also pointed out that it will speed processing and shorten the time before receiving payment if physicians will assume the responsibility of filling out claims for this, but in the long run it will decrease the cost of insurance and prove to the advantage of both the patient and the physician.

The Health Care Financing Administration has adopted the new ICDM-9 diagnostic and procedure code for hospitals. This will be the standard universal diagnosis and procedural code for hospitals, and the CPT-IV code will be the standard code for physicians' services.

OUTPATIENT SURGERY

A bill was introduced in the Georgia Legislature to require all third parties to make the same payment for surgery done on outpatients that they would pay for the surgery done as a hospital patient. Considerable interest has arisen in the bill, because it is obviously desirable to perform as many services as possible outside the hospital. Accomplishing this by law, however, raises some problems, since it is difficult to draw a bill which would serve the purpose without opening the door for establishment of out-patient surgical "mills."

The Committee on Third Party Relations voted to ask MAG to encourage by all possible means third parties to accept responsibility for payment for out-patient surgery. If this can be done voluntarily, it was felt that the result could be realized without establishing another law for patients and physicians to struggle with. The Committee felt that some progress might be made in this direction by encouraging the development of minimum standards for insurance contracts in Georgia to include payment for outpatient surgery, perhaps endorsed by the MAG.

CATASTROPHIC INSURANCE

Dr. J. Roy Rowland, Georgia House of Representatives, introduced a state catastrophic health insurance bill in the legislature. This bill has been assigned to a Study Committee.

The Committee on Third Party Relations felt that it would be desirable for representatives of the MAG to meet with Dr. Rowland during the Fall and prior to the next session of the Legislature to discuss various ways of making catastrophic insurance more generally available to the people in the state.

RECOMMENDATIONS

1. Defer any further action for the present time toward establishing a statewide fee schedule under Medicare and Medicaid.
2. Establish the policy that all tests performed in hospitals should be ordered by physicians, except as required by state law.
3. Inform third party carriers that MAG considers it highly desirable to encourage performance of appropriate surgery on an outpatient basis by providing adequate payments.
4. Inform MAG membership of the adoption of CPT-IV coding system by most third party carriers, including Medicaid, Medicare, and Blue Shield, Columbus, and encourage the use of this service code in submitting claims to the third party carrier.
5. Continue to encourage the use of second opinion consultations regarding elective surgery as a voluntary option for the patient.

(Addendum: It was recently discovered that Prudential will be marketing a mandatory second opinion program for its group policy holders. This is a reversal of Prudential policy and signals a change in the approach to second opinion programs from voluntary to mandatory second opinions.)

REFERENCE COMMITTEE DISCUSSION

Your Reference Committee read with interest the annual report of the Third Party Relations Committee and commends the Committee and the Chairman, Dr. Charles Hollis, for an outstanding job in tackling the multi-faceted assignments that have faced the Committee.

The 1978 House of Delegates charged the Committee with pursuing the possibility of establishing a statewide payment schedule under Medicare/Medicaid, after obtaining a survey to see what effect such a statewide fee would have on the metropolitan and rural areas of the state.

Medicare Part B, Prudential Insurance Company, has now completed two such surveys. The first survey (SAW-II) was an extremely sophisticated survey by specialty. The results would have required separate payment areas for physicians located in the same county. The government has ruled out the utilization of this method.

The second survey was done on the basis of the current Medicare payment system using the most frequently presented procedures. Because of Medicare regulations, specialty group considerations were also a part of this survey. The survey appeared to indicate that application would result in a reduction for 26% of the payments now being made, 34% would increase, and 40% would remain the same. The full impact of the implementation of a statewide fee on the basis of this study is not clear to the Committee at this point.

The Third Party Relations Committee's first recommendation is that any further action on establishing a statewide fee be deferred at this time. The Third Party Relations Committee feels that it would not be in the best interest of the state's physicians to request HEW to make a change in the payment schedules at the moment.

The Committee's second recommendation is that all tests performed in hospitals be ordered by physicians. This appears in keeping with previous cost containment suggestions.

The Committee's third recommendation is that third party carriers be encouraged to pay for appropriate surgery on an outpatient basis rather than requiring hospitalization.

The Committee's fourth recommendation is the adoption of the CPT-IV coding system.

The Committee's fifth recommendation is that MAG continue to encourage the use of second opinion consultations regarding elective surgery as a voluntary option for the patient.

RECOMMENDATIONS

Mr. Speaker, your Reference Committee advises the adoption of Recommendation 1.

Mr. Speaker, your Reference Committee advises that Recommendation 2 be amended to read, "Establish a policy recommending to hospital medical staffs that all tests performed in hospitals be ordered by physicians, except as required by state law," and that it be approved.

Mr. Speaker, your Reference Committee advises the adoption of Recommendation 3.

Mr. Speaker, your Reference Committee advises the adoption of Recommendation 4.

Mr. Speaker, your Reference Committee considered Recommendation 5 of the Third Party Relations Committee and Resolution 1 (Second Opinions Mandated by Third Party Payor) together and wishes that, after due consideration, Recommendation 5 be adopted.

HOUSE OF DELEGATES ACTION — Adopted Recommendations 1, 3, and 4 of the Third Party Relations Committee. The House adopted Recommendation 5 of the Third Party Relations Committee Report with the deletion of the words "second opinion." The House adopted in lieu of Recommendation 2, the Reference Committee substitute which read, "Establish a policy recommending to hospital medical staffs that all tests performed in hospitals be ordered by physicians, except as required by state law."

RESOLUTION 1
SECOND OPINIONS MANDATED BY THIRD PARTY PAYOR

Hall County Medical Society

WHEREAS, we believe the patient-physician relationship is the cornerstone of medical practice in this country, and

WHEREAS, since the conception of this physician-patient relationship as we know it, free and unrestricted consultation has always been an integral part of our system, and

WHEREAS, we believe this consultation is proper and indicated, whether initiated by the patient or physician, and

WHEREAS, any consultations or second opinions required by a third party will only serve to erode and eventually destroy the sanctity of this relationship, now, therefore, be it

RESOLVED, that the Medical Association of Georgia continue to support and encourage consultations; however, we are opposed to any interference in the patient-physician relationship, such as second opinions, either mandated or coerced by a third party, and be it further

RESOLVED, that this resolution is sent to each medical society in the state, asking that a similar action be taken.

REFERENCE COMMITTEE DISCUSSION AND RECOMMENDATION

Mr. Speaker, your Reference Committee considered Recommendation 5 of the Third Party Relations Committee and Resolution 1 (Second Opinions Mandated by Third Party Payor) together and wishes that, after due consideration, the following substitution be adopted for Resolution 1: Following the word "Georgia," in the first resolve, the Resolution would read, "Continues to support and encourage consultations. Further, MAG is opposed to any interference in the patient-physician relationship as a result of mandated or coerced second opinions." The remainder of the Resolution beginning with the words "and be it further" would be unchanged.

HOUSE OF DELEGATES ACTION — The House adopted the Reference Committee substitute for the first resolve of Resolution 1 as follows: "RESOLVED, that the MAG continues to support and encourage consultations. Further, MAG is opposed to any interference in the patient-physician relationship as a result of mandated or coerced second opinions." The second resolve was adopted as presented.

RESOLUTION 5
COUNTY CORONER SYSTEM

Colquitt County Medical Society

WHEREAS, the county coroner system, as elected officials responsible for investigating the death of all persons dying in any county in the State of Georgia, is obsolete and inefficient, and

WHEREAS, many states have now moved to a successful medical examiner system that establishes guidelines for qualified personnel to oversee the activities of the medical examiners, now, therefore, be it

RESOLVED, that the MAG recommend to the Georgia Legislature that the elected county coroner system be abolished and replaced with a statewide medical examiner system.

REFERENCE COMMITTEE DISCUSSION

This resolution would ask that MAG recommend to the Georgia General Assembly that the county coroner system be abolished and replaced by a statewide medical examiner system.

Your Reference Committee was advised that MAG's Medical Examiners System Committee reported to the MAG Board of Directors in December 1978. A motion passed that members of the MAG Board ask their respective legislators to develop legislation to establish a chief medical examiner and to establish nine district medical examiners' offices at a cost of approximately $2.5 to $3.4 million.

Your Reference Committee was further advised that Representative Sidney Marcus, Chairman of the General Assembly's Health and Ecology Committee, will be working on this problem this summer.

RECOMMENDATION

Mr. Speaker, your Reference Committee advises that Resolution 5 be adopted.

HOUSE OF DELEGATES ACTION — Adopted Resolution 5.

RESOLUTION 8
GEOGRAPHICAL FEE DETERMINATION

Laurens County Medical Society

WHEREAS, the 1975 MAG House of Delegates voted in favor of the following:

> "We should dedicate our efforts to see that every physician, urban, semi-urban, rural, or institutional should be paid a fee for service without regard to geographic location. The MAG should assist in every way possible to implement this policy. We should also continue in our efforts to provide a more equitable distribution of doctors to relieve shortages in underserviced areas," and

WHEREAS, in 1976, 1977, and 1978 the MAG House of Delegates has reaffirmed its desire to end fee discrimination based on geographic distribution, and

WHEREAS, the Committee on Third Party Relations has worked long and hard with the Bureau of Health Insurance and Prudential-Medicare to study and devise a plan whereby Georgia could be converted to a single prevailing fee area, and

WHEREAS, there has been interest shown and help provided by some influential people in Washington so that a non-binding "SAW II" study has been performed on prevailing fees in the State of Georgia, and

WHEREAS, this survey reveals that approximately 70% of the physicians' fees reported fall into a median group, (SAW 4), 20% below the median, and 10% above the median, and

WHEREAS, there are rumblings of possible legislation to set fees on a statewide basis in the near future, now, therefore, be it

RESOLVED, that the MAG again endorse the concept of usual, customary, and reasonable fees and opposes the discriminatory application of this concept in different geographic locations in the State of Georgia, and be it further

RESOLVED, that MAG Board of Directors work with the Health Care Finance Administration to establish one geographic reimbursement area in Georgia.

REFERENCE COMMITTEE DISCUSSION

Resolution 8 would ask that the MAG Board of Directors work with the Health Care Finance Administration to establish one geographic reimbursement area in Georgia.

Mr. Speaker, your Reference Committee wishes to advise the House that the same topic was addressed in the Third Party Relations Committee report (Recommendation 1).

RECOMMENDATION

Mr. Speaker, your Reference Committee wishes to advise that Resolution 8 be adopted with the deletion of everything following the words "in the State of Georgia" in the first resolve of the Resolution. A period would be substituted for the comma following the word "Georgia."

HOUSE OF DELEGATES ACTION — The House adopted Resolution 8 as amended by the Reference Committee.

RESOLUTION 12
STATEMENTS CONCERNING SPECIFIC THERAPEUTIC MODALITIES

Medical Association of Atlanta

WHEREAS, appropriate therapy for any illness must be determined by a patient's personal physician or physicians, and

WHEREAS, such decisions regarding therapy must be individualized to conform to the best interest of each patient, and

WHEREAS, specific therapeutic recommendations published as official policy statements by any medical organization could be interpreted as implying universal acceptance or rejection, recommending uniformity of treatment and mandatory conformance, now, therefore, be it

RESOLVED, that the House of Delegates of the MAG is opposed to sponsorship of any statements by medical organizations concerning specific therapeutic modalities (unless they are considered to be unscientific) that would imply official sanction or rejection and thereby suggest universal acceptance or rejection by the medical community, and be it further

RESOLVED, that upon adoption of this resolution, MAG's Delegates to AMA support this position when recommendations on specific therapeutic modalities are presented at the Annual Meeting of the AMA in Chicago in July 1979, or thereafter.

REFERENCE COMMITTEE DISCUSSION

Resolution 12 asks that MAG oppose any sponsorship of statements concerning specific therapeutic modalities (unless they are considered to be unscientific) and, further, that if the Resolution passes, that this position be supported at the AMA's summer 1979 meeting.

Resolution 12 pointed out that specific therapeutic recommendations published as official policy statements by any medical organization could be interpreted as implying universal acceptance or rejection, recommending uniformity of treatment and mandatory conformance.

Mr. Speaker, your Reference Committee wishes to advise that despite the merits of Resolution 12, such a sweeping resolution would be unduly restrictive on the Medical Association of Georgia.

RECOMMENDATION

Mr. Speaker, your Reference Committee wishes to advise that Resolution 12 be not adopted.

HOUSE OF DELEGATES ACTION — The House adopted Resolution 12 with the following amendments: The words "Therapeutic modalities" in the title would be changed to "Diagnostic and Therapeutic Medical or Surgical Treatment." In the first resolve, therapeutic modalities" would be changed to "diagnostic and therapeutic medical or surgical treatment" and the same change would apply to "therapeutic modalities" in the second resolve.

Chairman Blair expressed appreciation to all who participated in the deliberations and to Ken Williams of the MAG staff who assisted the Committee.

In the life of every successful physician there comes the temptation to toy with the Delilah of the press — daily and otherwise. There are times when she may be courted with satisfaction, but beware! Sooner or later she is sure to play the harlot, and has left many a man shorn of his strength, viz., the confidence of his professional brethren.

Aequanimitas, with Other Addresses,
"Internal Medicine as a Vocation"



Members of Reference Committee E (L-R): Mr. Bert Franco, MAG staff; Drs. Spencer Brewer, Atlanta; Donald Abele, Augusta; Alexander H. S. Weaver, Macon; and Edmund M. Molnar, Columbus.

Report of Reference Committee E

ALEXANDER H. S. WEAVER, M.D., Chairman
EDMUND M. MOLNAR, M.D., Vice-Chairman

Chairman Weaver reported to the House of Delegates that the reports and resolutions referred to Reference Committee E, which met in the North Harbor Room, DeSoto Hilton, Savannah, Georgia, on April 20, 1979, were thoroughly examined and carefully considered. The members of the reference committee present were Alexander H. S. Weaver, M.D., Chairman, Macon; Edmund M. Molnar, M.D., Vice-Chairman, Columbus; Donald C. Abele, M.D., Augusta; Joseph T. Christmas, M.D., Vienna; Spencer S. Brewer Jr., M.D., Atlanta; and H. E. Weems, M.D., Perry.

AMA DELEGATION

Harrison L. Rogers Jr., M.D., Chairman

Your AMA Delegates were again active in their representation of Georgia physicians at both 1978 meetings. Detailed reports of both the annual meeting in June at St. Louis and the winter meeting in December at Chicago have been provided in the MAG *Newsletter* after each meeting and will not be reproduced here.

At the June meeting, Harrison Rogers was again nominated as Vice Speaker and was elected without opposition for a second 1-year term. At that meeting, the number of items of business considered rose to 300, and for the first time specialty societies had direct representation in the House of Delegates. Consideration of the report of the National Commission on the Cost of Medical Care occupied much of the attention of the House and resulted in reaffirmation of previous positions, endorsement of some recommendations, and referral of others to the Board of Trustees for their reevaluation.

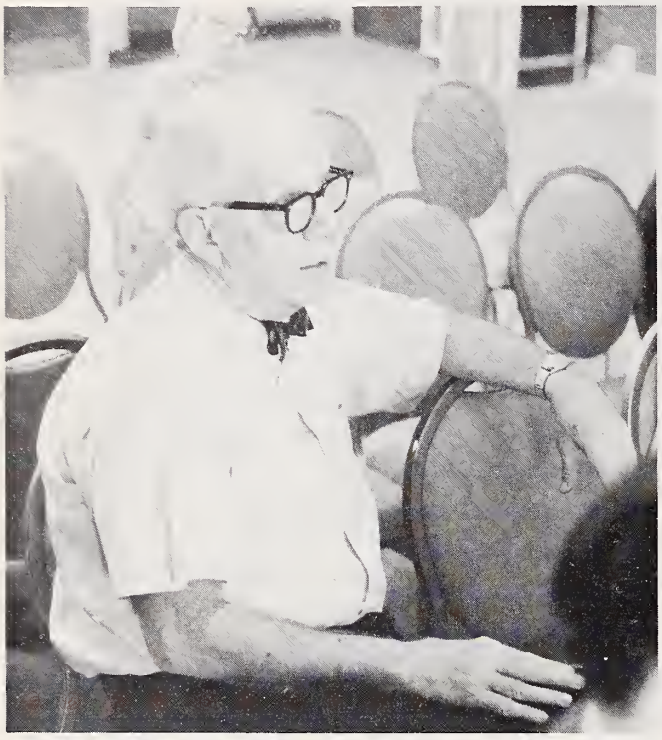
As part of the report by the delegation in the July *Newsletter* a request was made for MAG members to communicate their views on AMA matters to the Delegates and Alternates. We had a veritable storm of letters regarding the Chiropractic and Medical Ethics issues, and the Delegation supported the views of Georgia physicians both in Reference Committees and in the House of Delegates. Both these issues were clarified but neither has been settled and are certain to be before the House of Delegates for some time. These actions had already been reported to the membership via the *Newsletter,* as had the change in position of the House regarding sponsorship of a National Health Insurance Bill. As of this report it seems unlikely the AMA Board of Trustees will find it necessary to sponsor even a limited health insurance proposal prior to the July annual session of the House.

RECOMMENDATIONS

1. That MAG members be encouraged to attend the July 22-26 meeting of the AMA House in Chicago and the December 2-5 meeting in Honolulu.
2. That MAG staff be directed to investigate the feasibility of charter travel to Honolulu for our members.
3. That consideration be given by MAG House to inclusion of a resident physician and a medical student as voting members of the House.

REFERENCE COMMITTEE DISCUSSION

The report of the AMA Delegation of the MAG asks that MAG members be encouraged to attend the July 22-26 meeting of the AMA House in Chicago and the December 2-5 meeting in Honolulu and that MAG



AMA Vice-Speaker Harrison L. Rogers Jr. listens to Committee E discussion.

staff be directed to investigate the feasibility of charter travel for MAG members to the Honolulu meeting. The Delegation also asks that the MAG House of Delegates consider the inclusion of a resident physician and a medical student as voting members of this House.

RECOMMENDATIONS

Mr. Speaker, your Reference Committee E commends our AMA Delegation for its excellent job in representing the MAG in the AMA. Your Reference Committee advises that Recommendations 1 and 2 be adopted. Your Reference Committee also advises the adoption of Recommendation 3 with the addition of the words "and that the matter be referred to the appropriate MAG committees for specific recommendations with particular regard to dues, number of delegates, method of selection of delegates, and whom these delegates represent."

HOUSE OF DELEGATES ACTION — Adopted Recommendations 1 and 2 of the AMA Delegation and adopted Recommendation 3 as amended by the Reference Committee.

SECOND VICE-PRESIDENT

Richard A. Griffin III, M.D., Chairman

Your Second Vice President has attended most all of the MAG Executive Committee meetings and Board meetings this past year and at each of these the problems and issues of nurses or nurse practitioners has come to the attention of those committee members. I feel very strongly about this particular subject, and I feel that the nurse practitioner issue is a direct off-shoot of the discontinuation of the 3-year nurse's program. I would express to you my concern over this issue, that being an action by the American Nurses Association (ANA) House of Delegates to decide to encourage the closing of the 3-year hospital-based nursing schools.

I wish to bring to your attention an article which I read in the September 8, 1978, issue of the *AM News* in the "Letters to the Editor" section, entitled "The Future of Nursing." While this is not original with me, I do wish to incorporate the body of this article in my report, and I quote,

> "In 1965, the ANA House of Delegates decided to upgrade nursing by moving nursing education to colleges and universities, and requiring 4 years for nurses' training. At the same time, the ANA found that colleges and universities could not train an adequate number of RNs to satisfy the need for these skilled professionals. It found that education was too expensive. It also found that a number of people who were well qualified to be RNs could not afford or did not desire or did not have the educational qualifications to go to colleges and universities.
>
> The ANA, instead of recognizing its mistake and returning to the 3-year, hospital-based apprentice type of training with specific college courses, decided to downgrade nursing. It shortened the nursing period for training to 2 years. It took the student nurse out of the hospital. It granted the RN at the end of 2 years, and gave the RN the right to act as a registered nurse with inadequate training, to the detriment of our patients.
>
> I have talked with a number of hospital administrators, nursing superintendents, and physicians, and the majority agrees that the 3-year nursing school turns out the best bedside nurses. Even the 4-year program does not provide adequate bedside training.
>
> The ANA now proposes to wipe out the 3-year school entirely. It proposes to do away with the RN. It proposes to have an executive nurse from a university and what it calls a technical nurse from a 2-year community college. This will be bad for nursing, bad for patients, and bad for the medical profession."

Doctors tend to be gentlemen and consequently avoid getting involved with a program that they know from their own experience to be undesirable. I certainly feel that I have observed and experienced the undesirability of this process very frequently. One can well identify the type and amount of training among the three choices that one finds in a given nurse. It is almost therapeutic for the physician to have the opportunity to work with the nurse trained in the 3-year type RN program.

However, with the continuous encroachment into the practice of medicine created by Public Law 93-641, it is much more important to give more people less training in order to manage these programs than it is to strive for the quality in training. I would certainly hope to see a revival of interest in this particular phase of nurse training by the MAG. I sincerely hope that it is not too late to prevent the

elimination of the 3-year nursing school. These nurses have always been the backbone of nursing care and all it entails. After reading the article which I cited in my report from *AM News* concerning the discontinuation of the 3-year nurses program and noting that other physicians around the country are as equally concerned about this problem as I, this gives more reason to prevent this subject from being swept under the rug to the detriment of quality nursing. Therefore, I would make the following recommendations to the House of Delegates:

RECOMMENDATIONS

1. That the MAG go on record as being in favor of the continuation of the 3-year nursing program.
2. That an appropriate resolution in support of the 3-year nursing program be drafted by the MAG and given to MAG's Delegates to the AMA to be introduced at the next House of Delegates meeting of the AMA, and
3. That a copy of the AMA resolution, if passed, be forwarded to the ANA if the AMA so chooses.

REFERENCE COMMITTEE DISCUSSION

The report of the Second Vice-President asks that the MAG go on record as being in favor of the continuation of 3-year nursing programs, and that an appropriate resolution stating such be drafted and introduced by the MAG Delegation at the next meeting of the AMA House of Delegates. The report also asks that the ANA receive a copy of the AMA resolution if it passes.

The report specifically addresses the actions of the ANA which has recommended that by 1985 all registered nurses be graduates of 4-year training programs in colleges and universities, thus eliminating the 3-year diploma programs.

Mr. Speaker, your Reference Committee recognizes the value of maintaining the 3-year nursing programs, which have for years trained those forming the backbone of nursing care services. The deleterious effects of the phasing out of the 3-year programs are becoming ever more evident.

RECOMMENDATION

Mr. Speaker, your Reference Committee advises that the Report of the Second Vice-President be adopted and further advises that the MAG go on record as encouraging all 2-year nursing programs and 4-year nursing programs to upgrade the clinical experience given to their students.

HOUSE OF DELEGATES ACTION — Adopted the Report of the Second Vice-President as amended by the additional recommendation of the Reference Committee.

COMMITTEE ON ACCESS TO HEALTH CARE

M. Julian Duttera Jr., M.D., Chairman

The Access to Health Care Committee (meeting twice this year) continued many of the activities begun the previous year and considered several new projects. The Committee helped to sponsor the Second Annual Pre-Practice Seminar held at Callaway Gardens the weekend of September 29 to October 1. This conference, organized by the Southeastern Institute for Community Health, attracted 75 physician registrants and 45 community representatives. This was a substantial increase in participants over the previous year. Several changes in the format increased interaction between the community representatives and physicians. For the second year in a row, this conference received funds from the Callaway Foundation.

Acting on the recommendations of last year's House of Delegates, the Access to Health Care Committee explored the possibility of computerizing the MAG Physician Placement Service. This is being done, and appropriate questionnaires have been developed by the MAG staff for this purpose. This computer service will be able to print out the names, specialties, and other important information about all physicians who indicate an interest in practicing in the State of Georgia. The service will also provide physicians with a listing of the opportunities for placement. A limited amount of matching will be done through the service, which will allow physicians and communities to target their efforts in placement and recruitment. Initial start-up and annual operating funds were approved by the MAG Board at its September 1978 meeting, and it is expected the system will be completely operational by the end of this fiscal year.

The Chairman of the Access to Health Care Committee also chairs the Ad Hoc Committee to Study Rural Health Clinics and National Health Service Corps (NHSC) Physicians. This was undertaken in response to the concern expressed at the 1978 House of Delegates meeting that there was a lack of local participation of physicians in the placement of NHSC Physicians in Georgia and in starting rural health clinics. This ad hoc committee was created at the September 1978 MAG Board of Directors meeting and was charged with determining what mechanisms would be necessary to deal with the problems of NHSC Physicians and rural health clinics and what organizations would be helpful in coordinating the placement of these physicians. This ad hoc committee is still studying these problems, although the Medical Practice Committee has addressed itself to the problem of rural health clinics. Subsequent reports will be made to the Board of Directors on these subjects. Other states, specifically Tennessee, have developed local programs to deal with the NHSC problem and similar efforts are still being considered by the committee.

The Access to Health Care Committee recognizes that there are areas of unmet medical needs. Consequently, NHSC Physicians will continue to be placed throughout Georgia. In addition, the federal and state governments will continue to fund clinics in these areas. The Committee sees a need for some type of study to determine what problems new physicians are currently facing in establishing their practices, as well as why physicians remain or do not remain in these rural areas or underserved areas. This type of information would help physicians in general

and those involved in placing physicians in knowing why there are areas which are unable to attract physicians. They would also find out what physicians are attracted to when they look for practice sites.

RECOMMENDATIONS

1. That MAG continue to support the Pre-Practice Seminar at Callaway Gardens and that it increase its financial support for this conference during the 1979 year.
2. That MAG continue to support the physician placement service and the computerization of that service so that both physicians seeking communities and communities seeking physicians can have readily available information.
3. That steps be undertaken to insure that local physicians and county medical societies have input into the placement of NHSC personnel and that the appropriate agencies be advised of this input and informed that such input is necessary.
4. That the MAG undertake in the 1979-80 year a study of physicians recently entering the practice of medicine, and that this study examine those factors which will assist in the placement of physicians in rural areas.

REFERENCE COMMITTEE DISCUSSION

Your Reference Committee read with interest the annual report of the Committee on Access to Health Care and carefully considered the committee's report and recommendations. The Access to Health Care Committee has undertaken several new activities this past year and continued many of the efforts of previous years. These include the Pre-Practice Seminar held in conjunction with the Southeastern Institute for Community Health, the physician placement service, and the investigation of NHSC placement policies.

The committee's first recommendation asks that MAG continue its support for the Pre-Practice Seminar and increase its financial support to insure the continuation of the seminar. Last year this seminar brought together 75 physicians and representatives from more than 40 communities, assisting in the placement of physicians and preparing young physicians for practice in rural areas. There has been a considerable response on the seminar and its affect on the placement of physicians in the state.

The committee's second recommendation asks that MAG continue to support the computerization of the physician placement service. In response to the 1978 House of Delegates action, the MAG Board of Directors voted to provide funds to computerize the physician placement service, something which would not only cut costs, but also improve its operation. This is now being done and should be completed within the next few months.

The third recommendation asks that MAG work with the appropriate governmental agencies to get local medical society input into the placement of NHSC physicians. An ad hoc committee appointed at the September 1978 Board meeting has examined this to some extent and has reached no conclusions on the best means for dealing with this matter. Further deliberations on the subject are anticipated.

RECOMMENDATIONS

Mr. Speaker, your Reference Committee advises the adoption of Recommendation 1 with the addition of the words "if necessary" after the word "increase."

Mr. Speaker, your Reference Committee advises the adoption of Recommendation 2.

Mr. Speaker, your Reference Committee advises the adoption of Recommendation 3.

Mr. Speaker, your Reference Committee advises the adoption of Recommendation 4.

HOUSE OF DELEGATES ACTION — Adopted Recommendations 1, 2, and 3 of the Report of the Committee on Access to Health Care and adopted Recommendation 4 of the Committee as amended by the replacement of the word "undertake" with the word "endorse."

COMMITTEE ON CONSTITUTION AND BYLAWS

John T. Mauldin, M.D., Chairman

Your Committee and staff have been quite busy during the past year reviewing a number of county medical society constitution and bylaws. We have approved the Constitution and Bylaws of two new medical societies which were issued charters January 1, 1979, and will be represented in this House of Delegates at the April meeting in 1980. They are Blue Ridge Medical Society and the Douglas County Medical Society. We would urge each county medical society to search its records for its Constitution and Bylaws to make sure that each has a copy and that it is up to date, as your Constitution and Bylaws Committee would be most happy to review it to make certain it conforms with MAG's current Constitution and Bylaws. Once we have reviewed and approved it, we will be most happy to issue that county medical society a brand new charter.

Your Constitution and Bylaws Committee has been instructed by the Executive Committee to present to this House a bylaws change, found in Chapter V, Board of Directors, Section 3, Executive Committee. The language found in this section concerning the Second Vice-President and his right to vote at the Executive Committee meetings does not conform to Chapter VII, Rights and Duties of Officers, Section 3, the Vice-President. Current language in Chapter V, Board of Directors, Section 3, Executive Committee reads as follows:

> "The Second Vice-President and the Speaker of the House of Delegates, or in his absence, the Vice-Speaker, shall be ex-officio members of the Executive Committee; however, only the Speaker, or, in his absence, the Vice-Speaker, shall have the right to propose motions and to vote."

The language contained in Chapter VII, Rights and

Duties of Officers, Section 3, The Vice-President, reads as follows:

"... In his own right, the Second Vice-President shall be an ex-officio member of the Executive Committee without the right to vote, except in the absence of the First Vice-President."

As these two sections are in conflict with each other, we would recommend the following:

NOTE:

Existing wording appears here as is. Suggested amendments by addition are indicated by italics. Amendments by deletion are indicated by ~~striking through that which is to be deleted.~~ It is possible to read the wording as it is suggested. Only those sentences preceding and succeeding a suggested change that help to identify the suggested amendment are shown here.

Chapter V, Board of Directors, Section 3, Executive Committee,

"The Second Vice-President and the Speaker of the House of Delegates, or in his absence, the Vice-Speaker, shall be ex-officio members of the Executive Committee; ~~however, only~~ the Speaker, or, in his absence, the Vice-Speaker, shall have the right to propose motions and vote. *And the Second Vice-President, in the absence of the First Vice-President,* shall have the right to propose motions and to vote. The Executive Committee shall meet monthly between the meetings of the Board of Directors."

REFERENCE COMMITTEE DISCUSSION

The Committee on Constitution and Bylaws chartered two new medical societies this past year and requests all existing societies to review their Constitution and Bylaws to insure their conformance with MAG's current Constitution and Bylaws. The Committee asks that MAG's Bylaws be amended by altering the language of Chapter V, Board of Directors, Section 3, to allow the Second Vice-President to make motions and vote in the absence of the First Vice-President, thereby making this wording consistent with Chapter VII, Rights and Duties of Officers, Section 3, the Second Vice-President.

RECOMMENDATION

Mr. Speaker, your Reference Committee advises that the recommendation of the Committee on Constitution and Bylaws be adopted.

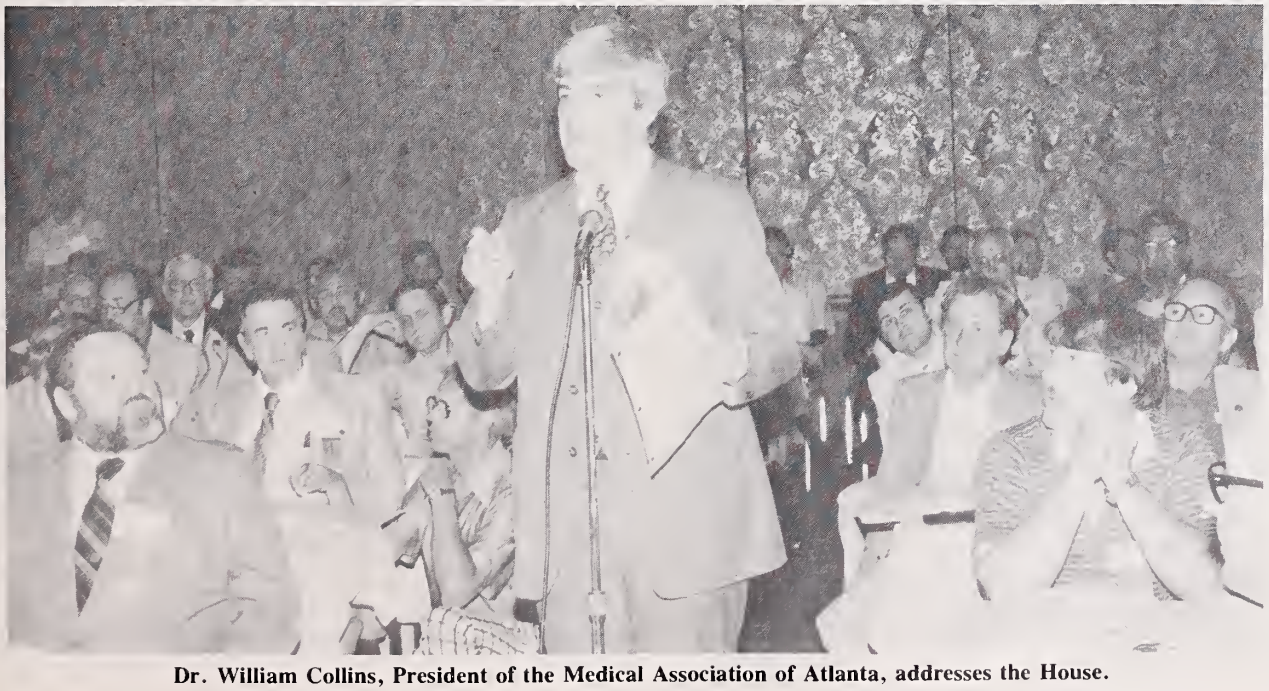
HOUSE OF DELEGATES ACTION — Adopted the Report of the Committee on Constitution and Bylaws.

MEMBERSHIP COMMITTEE

William C. Collins, M.D., Chairman

The membership of the MAG continues to increase. Once again, we have surpassed last year's membership totals, and have gone over the 4500 mark. Our active dues paying membership increased from 4010 members in 1977-78 to 4095 this year, an increase of 85. Our AMA membership increased from 3456 to 3524, an increase of 68.

We are now in our third year of our sliding-dues structure for those entering the medical profession and for those reaching 66 years of age and beyond. We are still of the opinion that the sliding scale for new members offers an excellent recruiting tool to approach new physicians. The schedule for older members is another way we can say thank you for the many years of service these physicians have given in Georgia.



Dr. William Collins, President of the Medical Association of Atlanta, addresses the House.

I am pleased to report the AMA has given a dues break to those physicians just entering practice, and has reduced their dues for one year only, in half, making their AMA dues $125 for their first year as a member of that Association.

As always, your Membership Committee continues to search for methods to enroll those Georgia physicians who have chosen not to belong to the medical societies. This year your Committee has asked MAG personnel to compile a list of all nonmembers of MAG that are currently licensed and practicing in the State of Georgia. This list which now has been compiled will be used in recruitment efforts by this Committee to send letters, either directly from MAG Headquarters or through the various county medical societies to every physician practicing in Georgia who is not a member, asking that he become a member and telling him some of the benefits of membership in the MAG, and also plugging the AMA.

Your Membership Committee has sent letters to all physicians who have passed the Georgia medical licensing exam, congratulating them on receiving the Georgia license, and extending to them our invitation to join the MAG and the AMA if they plan to have their permanent practice in Georgia. Your Membership Committee also sends out letters to all new MAG members welcoming them not only to the State of Georgia but into the membership of the MAG and extending our courtesies and services to them.

Several of the county medical societies have responded to this Committee's recommendations which were approved by the 1978 House of Delegates last year concerning the establishment of an active membership committee and each county society beginning to recruit more members. Your Membership Committee will continue to work and make every effort during the coming year to recruit new members, to look into new and innovative methods of not only bringing in new members but maintaining those we now have on our rolls, and will strive to keep this Committee active and viable in carrying out the charge given it by MAG.

With this in mind, your Committee wishes to make the following recommendations:

RECOMMENDATIONS

1. That each county medical society appoint a member to be responsible for membership recruitment within the medical staffs of all the hospitals in their county, or, where multiple hospitals exist, that a member be appointed for each hospital in the community.

2. That each member of this House of Delegates, upon returning to their own county medical society, recruit all physicians known to them in a face-to-face meeting, who are not members of organized medicine and actively solicit their membership.

3. That each county medical society actively recruit intern and resident members if they are in their areas and not members.

4. That as our AMA membership is only 477 away from having a fifth delegate from MAG to AMA, we would strongly recommend that each delegate seated at this House of Delegates who is not an AMA member join when they return home, and also personally contact all members of their society which are known to them as not being AMA members and recruiting them for AMA membership.

5. That each of us become and stay not only members in name but active participating members at all levels of organized medicine, in our county, state, and the AMA.

REFERENCE COMMITTEE DISCUSSION

The Report of the Membership Committee describes MAG's efforts to recruit new members into the organization. Of particular importance is the effort undertaken this past year to work with county medical societies in recruiting all non-MAG members licensed and practicing in Georgia.

The report of the Membership Committee asks that various activities be undertaken to increase MAG membership. These recommendations include: (1) that each county medical society appoint a member or members from the hospital staff(s) within each county to recruit new members; (2) that each delegate return to his county and actively recruit new members; (3) that each county medical society actively recruit interns and residents; (4) that a special effort be made to recruit MAG members into the AMA to qualify MAG for a fifth AMA Delegate; and (5) that each MAG member become more active in organized medicine.

RECOMMENDATION

Mr. Speaker, your Reference Committee advises that Recommendations 1 through 5 of the Membership Committee be adopted.

HOUSE OF DELEGATES ACTION — Adopted Recommendations 1 through 5 of the Committee on Membership.

GEORGIA STATE MEDICAL ASSOCIATION LIAISON COMMITTEE

Ronald F. Galloway, M.D., Chairman

Nothing has arisen during this past year to require either a formal meeting of this Committee or direct communication with the Georgia State Medical Association.

RECOMMENDATION

In that this committee has had no cause for action for several years, and in that any problem arising relating to the Georgia State Medical Association could be dealt with by the Executive Committee, the Board of Directors, or a special committee appointed at that time, it is my recommendation that the Georgia State Medical Association Liaison Committee be dissolved.

REFERENCE COMMITTEE DISCUSSION

The Report of the Georgia State Medical Associa-

tion Liaison Committee asks that the committee be abolished in that this committee has not met during the past year, has had no cause to meet with the Georgia State Medical Association, and in that the Executive Committee, Board of Directors, or other groups can deal with problems as they may arise. Your Reference Committee points out that at its March meeting the Executive Committee of MAG abolished this committee and directed the President of MAG to be responsible for maintaining liaison with the Georgia State Medical Association.

RECOMMENDATION

Mr. Speaker, your Reference Committee advises that the recommendation of the Georgia State Medical Association Liaison Committee be adopted, thereby abolishing the committee.

HOUSE OF DELEGATES ACTION — Adopted the Report of the Georgia State Medical Association Liaison Committee.

NUTRITION COMMITTEE

W. Daniel Jordan, M.D., Chairman

The Nutrition Committee was formed in 1978 for the purpose of evaluating some of the current trends in nutrition. The public has been deluged for the past several years with varying claims about the effectiveness and non-effectiveness of many common foods. In an attempt to analyze the mass of information so as to distinguish the sensational claims from the substantive ones, the committee selected seven topic areas for research and information. The committee felt that if it were able to explore a topic sufficiently, it could develop a position statement for the entire membership to study and use as a reference in answering questions that arise from the public. The committee selected the following seven topics for study: 1) vitamins, 2) sugars, 3) minerals, 4) preservatives, 5) processed foods, 6) disease and diet, and 7) food allergies. The study methodology involved individual and collective reading on an individual topic, devoting at least two meetings to each topic. Consultants are to be used to present in-depth information to the committee and to allow for direct questioning from the committee members.

The committee also requested position statements on nutrition and/or diet from many specialty societies and organizations. We were surprised to discover that a significant number of disease-specific organizations did not have previously adopted statements and frequently requested that we send them any information or conclusions that were developed. The list of groups contacted and their answers are available at MAG headquarters.

Fiber

Utilizing Sara Hunt, Ph.D., as a consultant, the committee developed a statement published in the March issue of the *JMAG*. (See attached Report from MAG's Nutrition Committee on Fiber.)

Sugars

The committee has been researching refined sugar since December 1978. It invited Dr. Thomas Huff from the Medical College of Georgia, Dr. John Davidson from Emory University School of Medicine, and Dr. Norris Bollenbeck from the Sugar Association to make presentations on refined sugar, its value and possible abuse, as well as possible effects in diabetes mellitus. It is anticipated that a position statement will be developed at the May meeting of the committee.

RECOMMENDATION

That the committee on nutrition be authorized to continue its investigations and its development of position statements for the dissemination of appropriate nutritional information to MAG members and to the public.

A Report from MAG's Nutrition Committee on Fiber

The Nutrition Committee of the Medical Association of Georgia has viewed with much interest the burgeoning research in the area of fiber intake and its possible relationship to health maintenance. Of particular interest to this committee is experimental evidence which suggests that certain components of fiber, notably pectin, may be effective in lowering serum cholesterol and improving glucose tolerance. Although much more research is needed in order to document the actual benefit of fiber components in prevention of disease, the suggestion that some benefit may exist prompts the committee to bring this dietary substance to the attention of the public. We have long known that sufficient fiber in the diet can be most helpful in regulating bowel habits and often can eliminate the need for laxative medications. Therefore, since dietary fiber possesses proven benefit in regulating bowel habits and possible benefit in deterring development of certain degenerative diseases, the committee would like to recommend that each Georgian evaluate his or her usual dietary habits in relation to intake of dietary fiber.

The following questions will prove helpful in assessing whether or not dietary fiber is a recognized constituent of the daily diet:

1. Are whole grain breads and/or cereals eaten regularly?
2. Are legumes often substituted for meat as a source of protein?
3. Are vegetables, often raw, eaten every day?
4. Are the skins of baked potatoes, baked apples, etc., consumed as part of the vegetable/fruit?
5. Are raw fruits often eaten as desserts or snacks?

If answers to all these questions are "yes" then more than likely a minimum of 30 grams of fiber daily is being consumed. The range of fiber intake, which appears feasible and probably desirable in most instances, is 30-60 grams daily.

One serendipitous aspect of the diet designed for its high fiber content is that foods contained therein are usually fairly low in calories. High fiber foods, for the most part, are quite bulky, and weight for weight are

lower in calories than are those which are more compact. Foods high in fiber then, because of their volume, have an increased satiety value and when used appropriately (i.e., substituted for other foods rather than added to an existing diet) can be most helpful in weight control.

Fiber-energy ratio is a term used to describe *the grams of fiber which may be obtained from that amount of a food supplying 100 kilocalories.*

In summary, the committee suggests that each person assess his/her own eating habits. When fiber consumption appears to fall below 30 grams daily, and no organic condition exists which requires fiber restriction, the committee recommends that substitutions be made in the diet so as to increase the fiber content. Such substitutions include: 1) use of whole grain bread and/or cereals in place of refined ones, 2) generous use of raw fruits and vegetables to replace high caloric desserts, casseroles, and pastries, 3) increased use of legumes as a source of protein to replace the over abundance of meat often consumed. A diet modified as described should prove to be beneficial, not only because of its increased fiber content, but also because of its potential for lowering energy intake, particularly that contributed by fat.

TABLE 1
FOODS WITH A HIGH FIBER-ENERGY RATIO

Food	Portion Size	Kilocalories	Fiber-Energy Ratio
Wheat flour, whole grain	2½ Tbsp.	60	3.0
Rye wafers	3 squares	64	3.5
Cantaloupe	½ cup	26	3.6
Wheat cereal, shredded	1 lg. pillow	84	3.62
Wheat cereal, flakes	¾ cup	75	3.93
Plums	2 medium	58	4.0
Bread, whole wheat	1 slice	63	4.2
Rye flour, dark	2½ Tbsp.	60	4.7
Orange	1 small	45	4.7
Beans, white	½ cup	91	4.7
Potatoes, white	1 small	80	4.8
Beans, kidney	½ cup	94	4.8
Bread, rye	1 slice	54	5.0
Corn, kernels	⅓ cup	41	5.2
Tangerines	1 medium	34	5.3
Strawberries	¾ cup	36	6.6
Apples	1 small	55	7.1
Squash, winter	½ cup	43	8.3
Cucumbers (raw)	½ cup	7	10.7
Carrots	½ cup	19	11.6
Peas	½ cup	44	11.8
Blackberries	½ cup	30	12.2
Radishes (raw)	½ cup	9	13.8
String beans	½ cup	12	14.2
Cabbage (raw)	½ cup	11	14.7
Bran (100%) cereal	½ cup	66	15.1
Lettuce (raw)	½ cup	3	16.7
Broccoli	½ cup	15	17.1
Squash, summer	½ cup	9	25.0
Zucchini	½ cup	9	27.3
Celery	½ cup	5	33.3

REFERENCE COMMITTEE DISCUSSION

The Committee on Nutrition asks that it be authorized to continue its investigations and its development of position statements for the dissemination of appropriate nutritional information to MAG members and to the public.

RECOMMENDATION

Mr. Speaker, your Reference Committee commends the Committee on Nutrition for its work during this past year and advises the adoption of its recommendation.

HOUSE OF DELEGATES ACTION — Adopted the Report of the Committee on Nutrition.

RESOLUTION 11
THE "RIGHT TO DIE BILL"
SENATE BILL 86, HOUSE BILL 630

Richmond County Medical Society

WHEREAS, the Richmond County Medical Society overwhelmingly passed a resolution opposing the passage of Senate Bill 86 (HB 630), and

WHEREAS, this legislation has not been adequately discussed and debated within the county medical societies throughout the State of Georgia at the grass roots level, and

WHEREAS, this legislation invites the unwarranted intrusion of the legislature and the legal profession between the physician and his seriously ill patient, and

WHEREAS, it is imperative that the MAG vigorously oppose the passage of any legislation which would compel practicing physicians in this state to engage in activities that they find morally reprehensible, and

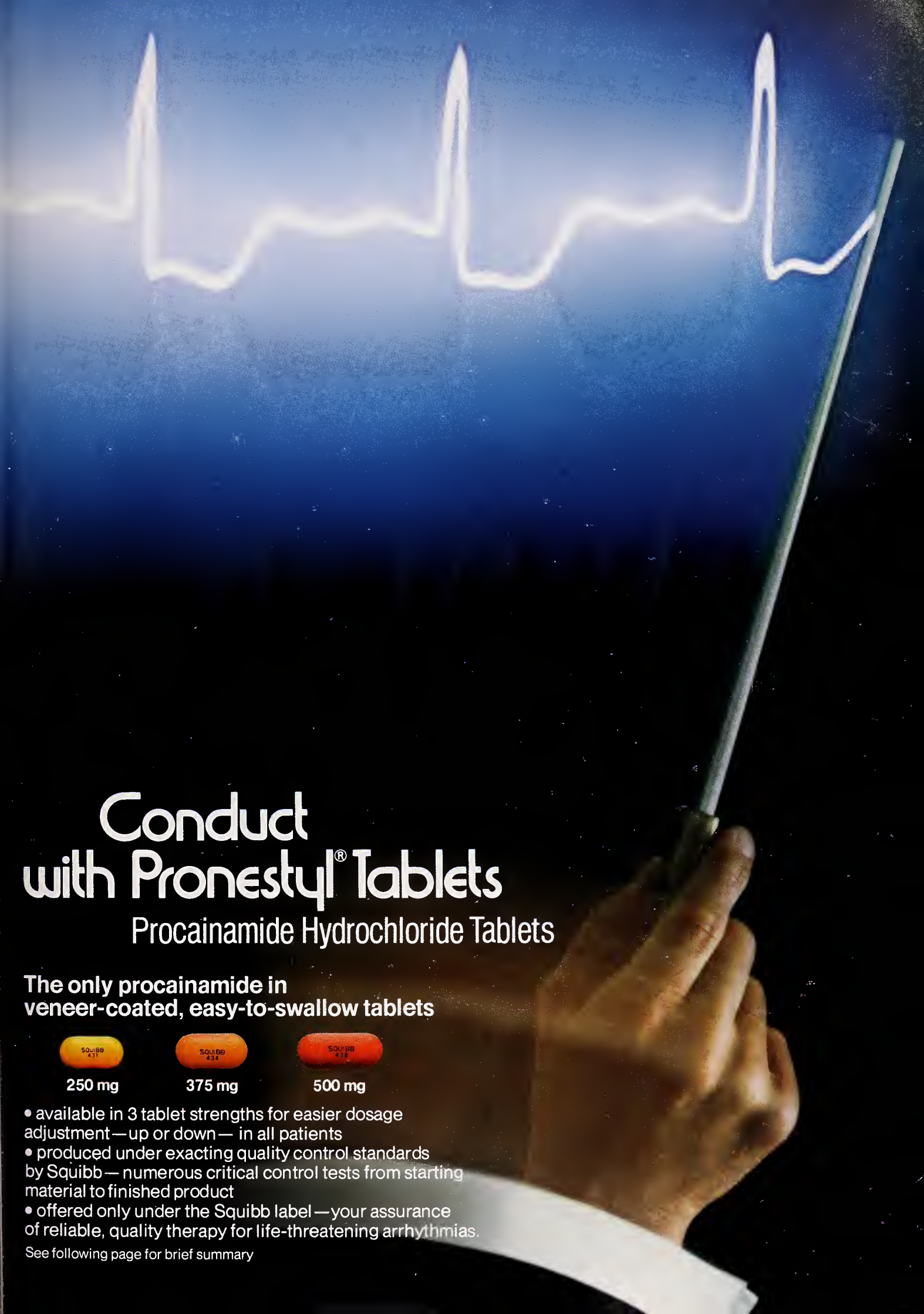
WHEREAS, there has never been a legal precedent nor legal case in the State of Georgia which would have been benefited by the existence of this bill, and

WHEREAS, this legislation clearly implies that physicians in this state commonly prolong the life of terminally ill patients in a rather haphazard, deliberate, and even malicious spirit rather than considering what is best for the patient in his/or her particular circumstance, and

WHEREAS, the seemingly innocuous title of this legislation in no way accurately reflects the inflammatory content of the actual bill, and

WHEREAS, this type legislation introduces too much room for peripheral considerations that could take precedence over what is truly best for the individual patient, now, therefore, be it

RESOLVED, that the MAG is in complete opposition to the concept and language of Senate Bill 86 (HB 630), thus completely reversing the favorable action which this bill received at the 1978 State Convention, and furthermore demands that the Georgia Senate and House of



Conduct with Pronestyl® Tablets

Procainamide Hydrochloride Tablets

The only procainamide in veneer-coated, easy-to-swallow tablets

250 mg 375 mg 500 mg

- available in 3 tablet strengths for easier dosage adjustment—up or down— in all patients
- produced under exacting quality control standards by Squibb— numerous critical control tests from starting material to finished product
- offered only under the Squibb label—your assurance of reliable, quality therapy for life-threatening arrhythmias.

See following page for brief summary

PRONESTYL® TABLETS
Procainamide Hydrochloride Tablets

The prolonged administration of procainamide often leads to the development of a positive anti-nuclear antibody (ANA) test with or without symptoms of lupus erythematosus-like syndrome. If a positive ANA titer develops, the benefit/risk ratio related to continued procainamide therapy should be assessed. This may necessitate considerations of alternative anti-arrhythmic therapy.

DESCRIPTION: Pronestyl (Procainamide Hydrochloride) is the amide analogue of procaine hydrochloride and is available for oral administration as veneer-coated tablets providing 250 mg, 375 mg, and 500 mg procainamide hydrochloride.

CONTRAINDICATIONS: In patients with myasthenia gravis and where a hypersensitivity to procainamide exists; bear in mind cross sensitivity to procaine and related drugs. Should not be given to patients with complete atrioventricular heart block. Contraindicated in cases of second degree and third degree A-V block unless an electrical pacemaker is operative.

PRECAUTIONS: Evidence of untoward myocardial responses should be carefully watched for in all patients. In the presence of myocardial damage with atrial fibrillation or flutter, the ventricular rate may increase suddenly as the atrial rate is slowed; adequate digitalization reduces but does not abolish this danger. Ventricular tachysystole is particularly hazardous if myocardial damage exists.

The dislodgment of mural thrombi producing an embolic episode may occur in correcting atrial fibrillation due to the forceful contractions of the atrium.

Extreme caution is required in attempting to adjust the heart rate when ventricular tachycardia has occurred during an occlusive coronary episode or where the use of procainamide may result in additional depression of conduction and ventricular asystole or fibrillation as in second degree and third degree A-V block, bundle branch block, or severe digitalis intoxication.

Bear in mind when treating ventricular arrhythmias in patients with severe organic heart disease and ventricular tachycardia that complete heart block, which may be difficult to diagnose, may be present. Since asystole may result if the ventricular rate is significantly slowed without attainment of regular atrioventricular conduction, procainamide should be stopped and the patient re-evaluated.

In the presence of both liver and kidney damage, normal dosage may produce symptoms of overdosage—principally ventricular tachycardia and severe hypotension.

A syndrome resembling lupus erythematosus has been reported with oral maintenance procainamide therapy. Common symptoms are polyarthralgia, arthritis and pleuritic pain. Fever, myalgia, skin lesions, pleural effusion and pericarditis may also occur. Rare cases of thrombocytopenia or Coombs-positive hemolytic anemia, possibly related to this syndrome, have been reported. Measure anti-nuclear antibody titers at regular intervals in patients on procainamide for extended periods of time or in whom symptoms suggestive of lupus-like reaction appear; in event of rising titer (anti-nuclear antibody) or clinical symptoms of LE, assess the benefit/risk ratio related to continued procainamide therapy (see boxed Warning). Steroid therapy may be effective if discontinuation of procainamide does not cause remission of symptoms. If the syndrome develops in a patient with recurrent life-threatening arrhythmias not otherwise controllable, steroid-suppressive therapy may be used concomitantly with procainamide.

ADVERSE REACTIONS: Hypotension is rare with oral administration. Serious disturbances of cardiac rhythm such as ventricular asystole or fibrillation are more common with I.V. administration.

Large oral doses may sometimes produce anorexia, nausea, urticaria, and/or pruritus.

A syndrome resembling lupus erythematosus has been reported in patients on oral maintenance therapy (see Precautions). Reactions consisting of fever and chills have been reported, including a case with nausea, vomiting, abdominal pain, acute hepatomegaly, and a rise in serum glutamic oxaloacetic transaminase following single doses of the drug. Agranulocytosis has been occasionally reported following repeated use of the drug, and deaths have occurred. Therefore, routine blood counts are advisable during maintenance procainamide therapy; and the patient should be instructed to report any soreness of the mouth, throat or gums, unexplained fever or any symptoms of upper respiratory tract infection. If any of these symptoms should occur and leukocyte counts indicate cellular depression, procainamide therapy should be discontinued and appropriate treatment should be instituted immediately. Bitter taste, diarrhea, weakness, mental depression, giddiness, psychosis with hallucinations, and hypersensitivity reactions such as angioneurotic edema and maculopapular rash have been reported.

For full prescribing information, consult package insert.

HOW SUPPLIED: Pronestyl Tablets (Procainamide Hydrochloride Tablets) providing 250 mg, 375 mg, and 500 mg procainamide hydrochloride are available in bottles of 100 and Unimatic® single-dose packaging in cartons of 100. The 250 mg and 500 mg tablets are also available in bottles of 1000.

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Representatives be informed directly as to the controversial nature of this particular type legislation.

REFERENCE COMMITTEE DISCUSSION AND RECOMMENDATION

Resolution 11 asks that the MAG be in complete opposition to the concept and language of Senate Bill 86 (House Bill 630) Right to Die Legislation and that the Georgia State Senate and House of Representatives be informed of the controversial nature of this type of legislation.

Mr. Speaker, your Reference Committee heard considerable testimony on both sides of this issue. Your Reference Committee would mention that the MAG vigorously supported passage of this bill in the 1979 session of the Georgia legislature. Your Reference Committee would further point out that this matter was discussed at length at the 1978 House of Delegates meeting and a decision was reached to support right to die legislation.

Mr. Speaker, your Reference Committee advises that Resolution 11 be not adopted and would ask that this House of Delegates reaffirm the actions of the 1978 House of Delegates by supporting the concept of the Living Will as embodying and protecting the patient's right to death with dignity, and that MAG work toward passage of the appropriate legislation in the Georgia legislature.

HOUSE OF DELEGATES ACTION — Voted that Resolution 11 be not adopted and that the House reaffirm its position (1978 House) in support of this concept and work to secure passage of appropriate legislation.

RESOLUTION 19

Commended Charles Todd, M.D.

WHEREAS, the Blue Shield Plan of Georgia/Atlanta and the Blue Cross Plan of Georgia/Atlanta have been combined for several years into one corporation entitled Blue Cross and Blue Shield of Georgia/Atlanta, Inc., and

WHEREAS, Dr. Charles Todd, a member of this House of Delegates and past president of the Medical Association of Atlanta, is the first physician to serve as chairman of the Board of this combined organization, and

WHEREAS, Dr. Charles Todd also serves as a member of the National Blue Shield Board of Directors, now, therefore, be it

RESOLVED, that this House of Delegates hereby commends the Atlanta Blue Plans for their wise choice in the selection of chairman of the Board, and be it further

RESOLVED, that Dr. Charles Todd be commended for his leadership in the health care field.

REFERENCE COMMITTEE DISCUSSION

Resolution 19 asks that this House of Delegates commend the Atlanta Blue Plans for their choice of Charles Todd, M.D., as Chairman of their Board and also commends Charles Todd, M.D., for his leadership in the health care field.

RECOMMENDATION

Mr. Speaker, your Reference Committee congratulates Dr. Todd on his selection as Chairman of the Atlanta Blue Plans and advises adoption of Resolution 19.

HOUSE OF DELEGATES ACTION — Adopted Resolution 19 as amended by the addition of the following:

"and be it further resolved that the House of Delegates commend all members of the MAG who have given of their time and efforts in serving on boards of various medically related organizations."

Chairman Weaver expressed his appreciation to the members of the Reference Committee for their time and efforts and thanked those who appeared before the Committee to express their views.



The competent physician, before he attempts to give medicine to his patient, makes himself acquainted not only with the disease which he wishes to cure, but also with the habits and constitution of the sick man.

Cicero: De oratore II, C. 80 B.C.



HELP WANTED

Many young people have a difficult time during that developmental period of confusion, stress and conflict called adolescence. For some, this period of adjustment leads to serious and complex emotional problems—special problems requiring special help.

That help is available for persons 13 to 19 years of age through the Adolescent Services of Peachtree and Parkwood Mental Health Center and Hospitals. Under the supervision of psychiatrists, a highly trained staff of professionals helps teenagers find more rewarding and healthy behavior. Supervision by the adolescent's own therapist insures that special needs are recognized and dealt with in the treatment plan.

Complete information on Peachtree and Parkwood's Adolescent Services may be obtained by writing or calling the Admissions Office, **Peachtree and Parkwood Mental Health Center and Hospitals,** 1999 Cliff Valley Way, N.E., Atlanta, Georgia 30329 (404/633-8431).

Accredited by the Joint Commission on Accreditation of Hospitals



Members of Reference Committee D — (L-R) Drs. D. Morton Boyette, Albany; Robert E. Wells, Atlanta; Chairman Luther M. Thomas Jr., Augusta; Jack A. Raines, Columbus; and Stephen Daniel, Ph.D., MAG staff.

Report of Reference Committee D

LUTHER M. THOMAS JR., M.D., Chairman
ROBERT E. WELLS, M.D., Vice Chairman

Vice Chairman Wells reported to the House of Delegates that Reference Committee D met in the North Harborview Room at the DeSoto Hilton Hotel in Savannah on Friday, April 20, 1979, and carefully considered all the items referred to the committee. Physicians on the Reference Committee were: Luther M. Thomas Jr., Augusta; Robert E. Wells, Atlanta; D. Morton Boyette, Albany; Joseph L. Mulherin, Savannah; Jack A. Raines, Columbus; and Richard A. Griffin III, Cartersville.

SPEAKER OF THE HOUSE

L. C. Buchanan, M.D.

During the past year as Speaker of the House of Delegates, and thereby as a member of the Board of Directors and of the Executive Committee, I have attended all regular and special meetings of each body with two exceptions. At all times I have attempted to be ever mindful of previous actions and policy decisions of the House of Delegates and, when necessary, have called to the attention of both groups when actions being considered by either appeared to conflict with prior House of Delegates action. The Board of Directors and the Executive Committee leadership have always been responsive and attempt to take action only when it is consistent with House declared policy.

At the suggestion of the Executive Committee, I attended a meeting of Speakers of the House of the 50 states sponsored by AMA held in December 1978 in Chicago. This meeting was well structured, well attended, and instructional. The attendees have requested that it be an annual affair, and I understand AMA plans to repeat in 1979.

The preplanning of the MAG Annual Session requires much more time than one might suspect. Again this year committee and departmental reports, officer reports (including this Speaker's Report), and resolutions continue to be submitted so late as to pose an almost insurmountable logistical problem. Early assignment of items to Reference Committees, printing, collation and distribution of the Handbook, meaningful pre-convention caucuses by those societies desiring them, etc., are seriously impeded or precluded by the late arrival of large numbers of such items. As in years past, the repeatedly announced deadlines for receiving these agenda items is largely ignored by those submitting items for consideration.

Only one resolution thus far submitted this year contained a fiscal note of estimated cost for implementation as directed by House action last year.

In order to expedite the work of the House of Delegates, increase its efficiency, decrease staff overtime and printing costs, and generally improve the orderly conduct of the Annual Session, the House of Delegates is respectfully requested to establish as policy the following recommendations:

RECOMMENDATIONS

1. Only those reports and resolutions received at least 30 days prior to date of convening the Annual Session will be printed, collated, and distributed in the Handbook.
2. The reports of officers, departments and committees and all resolutions received at headquarters after 30 days prior to date of convening will be duplicated and distributed to each delegate at time of registration. These will be referred to reference committees as indicated.
3. Those resolutions and reports containing recom-

mendations received during the 10 days immediately preceding the Annual Session will be reviewed by the Annual Session Committee and will be assigned to a Reference Committee only if their subject matter is considered of sufficient urgency as to demand inclusion on the agenda. Any late submitted item thus not included on the agenda may be introduced as an item of new business at the opening Session together with a request for its consideration to be voted on by the House of Delegates assembled.

It continues to be a privilege to serve as Speaker of the MAG House of Delegates.

(Fiscal note: No increased cost over present expenditures.)

REFERENCE COMMITTEE DISCUSSION AND RECOMMENDATION

The annual report of the Speaker of the House contains several recommendations designed to facilitate the more efficient conducting of the annual House of Delegates meeting. The first of these recommends that only those reports and resolutions received at least 30 days prior to the date of convening the Annual Session be printed and distributed in the handbook. Your reference committee is in agreement with this recommendation and advises that it be adopted.

HOUSE OF DELEGATES ACTION — Adopted the first recommendation of the Report of the Speaker.

REFERENCE COMMITTEE DISCUSSION AND RECOMMENDATION

The second recommends that reports of officers, departments and committees, and all resolutions received at the headquarters after 30 days prior to the date of convening be duplicated and distributed to each delegate at the time of registration and referred to reference committees as indicated. Your reference committee is in agreement with this recommendation and advises that it be adopted.

HOUSE OF DELEGATES ACTION — Adopted the second recommendation of the Report of the Speaker.

REFERENCE COMMITTEE DISCUSSION AND RECOMMENDATION

The third recommendation calls for those resolutions and reports containing recommendations received during the 10 days immediately preceding the Annual Session to be reviewed by the Annual Session Committee and assigned to a reference committee only if their subject matter is considered of sufficient urgency as to demand inclusion on the agenda. Any late submitted item thus not included on the agenda may be introduced as an item of new business at the opening session together with a request for its consideration to be voted on by the House of Delegates assembled. Your reference committee heard a discussion of this recommendation and felt that further clarification is needed about the method of House approval for placing late-submitted items on the House agenda.

Mr. Speaker, your Reference Committee D advises adoption of the following substitute recommendation: "Those resolutions and reports containing recommendations received during the 10 days immediately preceding the Annual Session will be reviewed by the Annual Session Committee and will be assigned to a reference committee only if their subject matter is considered of sufficient urgency as to demand inclusion on the agenda. Any late submitted item, if it is not included on the agenda, may be introduced as an item of new business at the opening session of the Annual Session if approved by a majority vote of the House of Delegates. After the opening session a late submitted item may be included on the agenda only with the unanimous approval of the House."

HOUSE OF DELEGATES ACTION — Adopted the third recommendation of the Report of the Speaker as amended by the Reference Committee.

COMMITTEE ON EDUCATION

LaMar S. McGinnis Jr., M.D., Chairman

This committee is charged by the Association as follows: "The Education Committee shall work to foster the development of high quality continuing education programs for physicians throughout the state. It shall also promote comprehensive health education in the schools, patient education, and health education for the general public. The Committee shall maintain liaison with the medical schools and with other institutions and agencies which provide medical and health education."

The continuing interest and participation of the members of our large committee is most heartening. Attendance at quarterly meetings is excellent, and much work is carried on by individual members and subcommittees between these quarterly meetings. However, we would continue to recommend that the membership of the committee be reviewed on an annual basis and that those members with a waning interest in the activities of the committee should be relieved of the responsibility and newly interested members appointed. The nationwide heightened interest by physicians in continuing medical education (CME) continues, but at a somewhat more level plane, as experience teaches us what is really important. The initial surge toward mandatory CME by state medical societies and licensing boards seems to be decreasing as poor experience with such requirements is encountered. A new standard from the 1979 Accreditation Manual for Hospitals, published by the Joint Commission on Accreditation of Hospitals, which simply states, "The medical staff shall participate in a program of continuing education," is causing heightened interest by hospitals and staff members in the establishment of hospital CME programs. It is the responsibility of the MAG to assist these hospitals and our member physicians in these efforts. The interpretation of the standard states that there shall be a program of continuing education for all hospital staff members, the program shall be on a regular and recurring basis, the degree of participation of each staff member shall be documented, and participation in CME programs

outside the hospital should be documented. This information should be incorporated into each staff member's file for evaluation, and there should be evidence that all staff members have participated in basic cardiopulmonary resuscitation training and are considered so qualified. Medical staff members should concern themselves with the adequacy of their professional library services and should seek accreditation of their hospital CME programs where possible.

The activities of our committee are wide and varied and extend from the annual MAG Scientific Assembly (this last year held in conjunction with the Southern Medical Association), to public health education, patient education, liaison with our state medical schools, encouraging medical library programs in hospitals, accreditation of CME programs, special educational programs such as the "Private Enterprise Perspectives on Medicine" Seminar (to be held in May 1979), practice management workshops, and the cornerstone of our program — the improved availability of CME programs at the local level.

Let us now detail more specifically the activities of the committee. Following is a listing of all of the accredited CME programs within the state, with most of them accredited through the MAG:

American Academy of Pediatrics, Georgia Chapter
American Cancer Society, Georgia Division
American College of Chest Physicians, Georgia Chapter
American College of Physicians, Georgia Chapter
Atlanta Graduate Medical Assembly
Atlanta Society of Pathologists
Center for Disease Control (CDC)
DeKalb General Hospital, Decatur
Emory University School of Medicine and affiliated hospitals
Georgia Academy of Family Physicians Educational Foundation
Georgia Baptist Hospital, Atlanta
Georgia Heart Association
Georgia Psychiatric Association
Georgia Radiological Society
Georgia Rheumatism Society
Georgia Society of Anesthesiologists
Georgia Society of Ophthalmology
Georgia Surgical Society
Martin Army Hospital, Fort Benning
Medical Association of Georgia
The Medical Center, Columbus
Medical Center of Central Georgia, Macon
Medical College of Georgia and affiliated hospitals
Memorial Medical Center, Savannah
Northside Hospital, Atlanta
Phoebe Putney Memorial Hospital, Albany
Piedmont Hospital, Atlanta
Scottish Rite Hospital, Atlanta
Southeastern Angiographic Society
Tanner Memorial Hospital, Carrollton
University Hospital, Augusta

Following is a listing of Education Committee activities as related to our subcommittee structure:

A. Accreditation Subcommittee — Chairman: Dr. James Maughon
 1. Conducted site surveys of four hospitals (Scottish Rite Hospital, Atlanta; Athens General Hospital and St. Mary's Hospital, Athens; West Paces Ferry Hospital, Atlanta); one specialty society (Greater Atlanta Otolaryngology Society); and one voluntary health organization (Georgia Heart Association).
 2. Conducted resurveys of 10 already-accredited organizations.
 3. Sent requested accreditation materials to 13 hospitals, three specialty societies, two medical societies, and two private medical organizations.
 4. Sponsored a resolution in the AMA House of Delegates to give state medical societies the authority to accredit intrastate CME programs and to more clearly delineate responsibilities between state medical associations and the LCCME in the accreditation process.

B. Hospital Continuing Medical Education Subcommittee: Chairman: Dr. Dan Cabaniss
 1. Developed the concept of regionalizing hospital CME so that physicians with special talents and interests in CME in each of seven regions or areas of the state could work with all the hospitals in their respective regions to develop quality CME programs that may subsequently be accredited.
 2. The MAG Director of Education traveled to a number of hospitals to promote CME and its accreditation: Duluth, Marietta (2 hospitals), Atlanta (3 hospitals), LaGrange, Douglasville, Gainesville (2 hospitals), Waycross, Brunswick, and Savannah. Several committee members also traveled outside their own cities to give CME consultation to hospitals that had requested help.
 3. The chairman of the Education Committee and the MAG Director of Education met with the Education Council of the Georgia Hospital Association to inform the association of MAG's activities in this area and to discuss ways of coordinating and financing hospital CME programs.

C. Health Education Subcommittee — Co-chairmen: Drs. Nicholas Davies and John Harrel
 1. Promoted, coordinated, and shared information on health education programs through a group (under Education Committee's aegis) which includes representatives of the various organizations and agencies concerned. The group focused for a while on education to combat the problem of teenage pregnancy and is organizing a special issue of the *JMAG* on this subject. Health education in the schools is another concern of this subcommittee.
 2. Conducted a survey on smoking in health-related facilities and published the results in the *JMAG* and *Newsletter*.
 3. Helped plan a health fair to be sponsored by one of the Atlanta TV stations.
 4. Assisted MAG's Public Relations Department

with suggestions of topics and speakers for the statewide weekly radio program "For Good Health."

D. Medical Schools Subcommittee — Chairman: Dr. Lois Ellison
Has continued to meet regularly with representatives of the three on-going medical schools within the state and the proposed medical school for Macon. Also, housestaff and student representatives have been active participants. This committee has reviewed the stated objectives of each separate medical school; is encouraging articles from the medical staffs for the *JMAG* on subjects such as medical school admissions, curriculum, housestaff education, cost of medical education, etc.; and is planning a general conference on medical education to be held during the 1979 Scientific Assembly to continue to afford opportunity for communication between practicing physicians and the medical schools.

General CME Activities of MAG's Division of Education

1. Studied the results of an all-member survey on CME and published an article on the survey in the *JMAG*.
2. Drew up a position statement on mandatory CME.
3. Maintained a medical meeting calendar of all CME meetings in the Southeast (published monthly in the *JMAG)*.
4. Helped plan and coordinate the 1978 MAG-SMA Scientific Assembly, attended by over 2,500 physicians in all specialties.
5. Sponsored a talk on the future of medical education by C. H. William Ruhe, M.D., AMA Senior Vice President, as the annual Calhoun Lecture.
6. Sponsored three practice management workshops for residents preparing to enter private practice and one workshop for medical office managers.
7. Promoted the Physician's Recognition Award by adding the MAG seal and a cover letter to each PRA certificate awarded to a Georgia physician by the AMA; also published names of PRA recipients in the *JMAG*.
8. Sponsored a CME exhibit at the Atlanta Graduate Medical Assembly.
9. Helped plan an AMA regional CME meeting to be held in Savannah May 19-20, 1979.
10. Planned a seminar on "Private Enterprise Perspectives on Medicine" (PEP) to be held in Atlanta May 26-27, 1979 — planning committee chaired by Stephen May, M.D.
11. Evaluated the possibility of the computer recording of CME credits, utilizing MAG's Computer Department. Recommended against proceeding in this area because of the estimated initial cost of $13,300 for the first year and $5,300 for subsequent years.

Directives to the Education Committee

At the 1978 meeting of the House of Delegates, the Education Committee was directed to investigate various alternatives as to how the MAG might approach the value of mandatory CME. At the June meeting of the MAG Board of Directors it was recommended that the results of the study of the value of mandatory CME should be further considered by the 1979 House of Delegates. As a result of the careful analysis of the information derived from our survey, and as a result of current trends in CME, the Education Committee offers the following statement.

Statement on Mandatory CME

All members of the MAG are strongly encouraged to follow the recommendations of their specialty societies and specialty boards on the desirable amount of participation in CME activities. Such recommendations are probably better received than those emanating from other sources.

The MAG should not support the concept of mandatory CME for re-registration of the license to practice medicine. The primary purpose of relicensure should be to assure that the physician is competent to continue rendering quality care; and since there has not yet been convincing proof linking CME to physician competence, it would be premature to mandate CME for relicensure. States with such requirements have encountered considerable problems with enforcement and administration.

There should be no CME requirement for membership in the MAG. The physician's best motivation for participation in CME is not coercion but the desire to maintain professional knowledge and ability through education. It would be most difficult to design and administer a system of mandatory CME which gives proper credit to the best ways in which each physician learns.

The MAG strongly supports the development and accreditation of quality CME programs in local hospitals. Although every staff member's participation in hospital CME activities should be documented and reviewed at the time of reappointment, it should be left to the individual hospital to determine whether or not there should be a CME requirement for staff privileges.

Voluntary achievement in CME should be a major priority not only for the Education Committee but for the entire MAG. To accomplish this, the MAG should set a goal of having 100% of its members qualify for the AMA's Physician's Recognition Award within the next 5 years. This would be a positive action on MAG's part to go along with its opposition to forms of mandatory CME.

Smoking

The House also directed the Education Committee to conduct a poll of MAG members about the effectiveness of their campaign to eliminate smoking in their offices and other health facilities. This poll has been reported in the *JMAG*. There was a 3% response from our membership and a 54% response from the Georgia Hospital Association membership. From the poll it would seem that the majority of physicians are aware of MAG's position on smoking in medically-related facilities and do not allow smoking in their offices. About half of our membership responding indicated that they had personally attempted to

gain support for policies which would reduce smoking in hospitals or medically-related facilities. Some 75% of hospitals indicated that they had developed policies which would reduce the incidence of smoking therein, and some 60% indicated that staff physicians had urged hospitals to curtail smoking in their institutions.

Finally, I would like to thank the many members of the Education Committee for their continuing enthusiasm and support, and particularly to thank Dr. Stephen Daniel and Ms. Sue McAvoy of the MAG staff for their continued dedication, hard work, and persistence on behalf of our committee.

RECOMMENDATIONS

1. That the MAG support an area or regional concept of CME whereby interested and talented physicians in this field would be organized on an area basis to assist other hospitals within their areas in developing accredited CME programs which would be readily available to practicing physicians in their own locale and directly related to practice needs.

2. That the MAG adopt the statement on mandatory CME as offered in this report.

3. That the MAG, through its membership, pursue a more vigorous campaign to eliminate smoking in health care facilities (hospitals, clinics, physicians' offices, etc.).

4. That the MAG, through active encouragement of its officers, directors, delegates, and general membership, insure a large attendance for the "Private Enterprise Perspectives on Medicine" Seminar to be held at the Colony Square Hotel in Atlanta on Saturday afternoon, May 26, and Sunday morning, May 27, 1979.

5. That the MAG, through its various committees and through its membership, continue to encourage programs that would increase the quality and the amount of public health education, patient health education, and school health education.

REFERENCE COMMITTEE DISCUSSION AND RECOMMENDATION

Your reference committee read with interest the comprehensive report of the Committee on Education and wishes to commend the committee and its outgoing chairman, Dr. LaMar S. McGinnis Jr., on the committee's untiring efforts to provide quality continuing education to physicians and health education to the public. The report contains five recommendations, and your reference committee suggests that each be considered separately.

The first recommendation is that MAG support regional directors of CME who would assist hospitals in their regions in developing accredited CME programs. These programs would be readily available to practicing physicians in their own locale and directly related to practice needs.

Mr. Speaker, your Reference Committee D understands that the promotion of continuing education for physicians on the local level is one of the most important activities of the Education Committee and therefore advises that the recommendation be adopted. The fiscal note for this recommendation has been referred to Reference Committee F.

HOUSE OF DELEGATES ACTION — Adopted Recommendation 1 of the committee report.

REFERENCE COMMITTEE DISCUSSION AND RECOMMENDATION

The second recommendation is that the MAG adopt the statement on mandatory CME as offered in the committee's annual report. The statement is a result of the charge given to the committee by the 1978 House of Delegates to study the issue of mandatory CME and report back to the 1979 House. In summary, the statement calls upon physicians to follow the suggestions of their own specialty societies on the desirable amount of CME. The statement also opposes various forms of mandatory CME, such as a CME requirement for relicensure or membership in the MAG. The statement ends with a positive note by calling upon MAG members to demonstrate voluntary achievement in CME by obtaining the AMA's Physician's Recognition Award. Toward this end, the MAG should set a goal of having 100% of its members qualify for the award within the next 5 years.

Mr. Speaker, your Reference Committee D finds that the statement on mandatory CME is excellent and advises that it become official MAG policy with two minor changes to shift the emphasis from a negative to a positive one. Since the statement is not only a statement about mandatory CME but also about MAG's positive support for CME in general, your reference committee advises that the statement be given the title "Statement on Continuing Medical Education," deleting the word "mandatory" from the original title. In line with this change, your reference committee also advises that the word "mandatory" be deleted from the first sentence of the second paragraph of the statement. Mr. Speaker, your reference committee advises adoption of the statement with the changes noted.

HOUSE OF DELEGATES ACTION — Adopted Recommendation 2 of the committee report as amended by the Reference Committee.

REFERENCE COMMITTEE DISCUSSION AND RECOMMENDATION

The third recommendation calls for the MAG to pursue a more vigorous campaign to eliminate smoking in health care facilities, such as hospitals, clinics, and physicians' offices.

Mr. Speaker, your Reference Committee D heard no opposition and advises adoption of this recommendation.

HOUSE OF DELEGATES ACTION — Adopted Recommendation 3 of the committee report.

REFERENCE COMMITTEE DISCUSSION AND RECOMMENDATION

The fourth recommendation concerns the seminar "Private Enterprise Perspectives on Medicine" to be

held at the Colony Square Hotel in Atlanta on May 26-27, 1979. The recommendation calls for the MAG, through the active encouragement of its officers, directors, delegates, and general membership, to insure a large attendance at the meeting.

Mr. Speaker, your Reference Committee D believes this meeting will be a valuable educational experience and advises adoption of the recommendation.

HOUSE OF DELEGATES ACTION — Adopted Recommendation 4 of the committee report.

REFERENCE COMMITTEE DISCUSSION AND RECOMMENDATION

The fifth recommendation calls upon the MAG to continue to encourage programs that would increase the quality and amount of public health education, patient health education, and school health education.

Mr. Speaker, your Reference Committee D, hearing no opposition to these activities, advises adoption of the recommendation.

HOUSE OF DELEGATES ACTION — Adopted Recommendation 5 of the committee report.

COMMITTEE ON COST ACCOUNTABILITY

H. Duane Blair, M.D., Chairman

During the past year, the attention of the public has been focused more and more on the rising cost of health care. Not only have increases due to inflation been in the public eye, but the total overall cost due to such diverse factors as increased accessibility, increase in third party payment, advances in medical technology, and an aging population with more health problems have been widely discussed.

The major activities of the Cost Accountability Committee this past year have involved cooperation with the Georgia Hospital Association and other agencies in the "Georgia Voluntary Effort for Cost Effectiveness in Health Care." Although this is an expensive endeavor, there has been a very definite decrease in the rate of increase of hospital expenditures in the State of Georgia during the past year. The voluntary effort remains extremely active and hopefully the rate of increase in hospital expenditures in Georgia in the coming year will continue to decline.

The Cost Accountability Committee has felt that an understanding of the nature and cause of health care expenditures among multiple groups is necessary to come to grips with the problem of health care costs which are far outstripping the rise in expenditures of other areas of the economy. A multiple disciplined conference on Cost Effective Health Care was sponsored by the Committee on August 26, 1978, at the Peachtree Plaza Hotel in Atlanta, Georgia. Representatives from the AMA, the American Hospital Association, the National Education Association (as a representative of a labor group), the Health Insurance Association of America, Goodyear Tire and Rubber Company (as a representative of the business community), the National Blue Cross and Blue Shield Association, and the Department of HEW comprised a forum which examined the multiple facets of health cost as seen from their respective viewpoints. The conference was well attended by members of the MAG. A number of recommendations have been formulated from this conference and have been distributed to the component county medical societies and to participants in the conference.

We feel that all physicians are becoming more aware of the problem of increasing cost of medical care and of the necessity for cost awareness in the profession. However, we will continue to publicize the various aspects of this problem in the future. The activities of the Cost Containment Committee of the Medical Association of Atlanta have been noted by the MAG Cost Accountability Committee with pleasure. Hopefully, similar committees and many local medical societies in Georgia will follow this example and become involved with other entities in their respective communities to enhance the knowledge of the problems associated with increasing medical cost and how all involved can effectively work together at the local level to reduce the rate of this increase.

RECOMMENDATIONS

We would like to specifically recommend:

That the MAG remain active in the voluntary effort to contain hospital cost.

REFERENCE COMMITTEE DISCUSSION AND RECOMMENDATION

Mr. Speaker, your Reference Committee D read with interest the annual report of the Committee on Cost Accountability and wishes to commend the committee and its chairman, Dr. Duane Blair, for its dedicated work, including the organization and sponsorship of a statewide Conference on Cost Effective Health Care last August. The report contains a recommendation that the MAG remain active in the voluntary effort to contain hospital costs. Your reference committee is in agreement with this recommendation and advises that it be adopted.

HOUSE OF DELEGATES ACTION — Adopted the recommendation of the committee report.

REFERENCE COMMITTEE DISCUSSION AND RECOMMENDATION

Your Reference Committee heard some discussion about the appropriateness of the term "cost accountability" for the issues being addressed by the committee. It was pointed out that physicians cannot be held accountable for most of the increased cost of medical care, since many other factors, including inflation, are involved. Therefore, your Reference Committee suggests that the term "cost containment" is a more accurate description of the committee's activities. In line with this, your Reference Committee wishes to add a further recommendation that the name of the committee be changed to the Committee on Cost Containment.

HOUSE OF DELEGATES ACTION — Delegate D. Morton Boyette moved to amend the recommendation by substituting the phrase "cost awareness" for the phrase "cost containment." The recommendation of the Reference Committee was adopted as amended.

RESOLUTION 4
BLUE SHIELD FUNDING OF MCG PROGRAM FOR COST CONTAINMENT

Dougherty County Medical Society

WHEREAS, the escalation of costs of medical services has become a reasonable and major concern of physicians, patients, and government, and

WHEREAS, organized medicine is making an intensive voluntary effort to slow the increase in costs, and

WHEREAS, physicians direct the choice of services for which money is spent, and

WHEREAS, increased physician awareness of costs would allow the physician to choose the most economical services consistent with quality care, and

WHEREAS, the Medical College of Georgia has developed an innovative program to increase awareness of costs of various elements of patient care among students and house staff, and

WHEREAS, Physicians Services, Inc., the Blue Shield Plan of Columbus, has agreed to provide initial funds for this program, now, therefore, be it

RESOLVED, that the MAG commend the Medical College of Georgia for its progressive efforts to assist young physicians to be more responsible in cost containment of medical services, and, be it further

RESOLVED, that the MAG express its appreciation to the Blue Shield Plan of Columbus for funding this program.

REFERENCE COMMITTEE DISCUSSION AND RECOMMENDATION

Two resolutions also dealing with cost containment were discussed in conjunction with the above report.

Resolution 4 notes with pleasure that the Medical College of Georgia has developed an innovative program to increase awareness of costs of various elements of patient care among students and house staff and calls upon the MAG to commend MCG for this program and to express its appreciation to the Blue Shield Plan of Columbus for funding the program.

Mr. Speaker, your Reference Committee D is in wholehearted agreement with the timeliness of such a program for medical students and house staff and therefore advises adoption of the resolution.

HOUSE OF DELEGATES ACTION — Delegate Joseph P. Bailey moved to amend the resolution by inserting the words "School of Medicine" after the phrase "Medical College of Georgia." The amended resolution was adopted.

RESOLUTION 9
MAA COST ACCOUNTABILITY COMMITTEE REPORT

Medical Association of Atlanta

WHEREAS, a special committee of the Medical Association of Atlanta, composed of physicians and a large majority of non-physicians representing important segments of the community such as business, labor, communications, retail industry, automotive, utilities, aircraft, government, insurance, etc., has prepared a significant Report of Cost Accountability in the area of health care, and

WHEREAS, typical recommendations in the Report are:

—To physicians — carefully plan admissions to and discharge from a hospital so as to make the most effective use of the hospital staff, and to avoid prolonging a hospital stay for non-medical reasons.

—To patients — assume a greater responsibility for and knowledge of their own health and medical histories. Also, do not over-use health insurance benefits, "just because they are there."

—To business, labor, and industry — review insurance plans with a view to revising features that encourage unnecessary use of physicians and hospitals.

—To third party payors (insurance, government) — be more aggressive in identifying questionable or abusive patterns of utilization, or questionable or excessively high charges, on the part of physicians and hospitals.

—To the Administration and Congress — review and evaluate existing initiatives which tend to expand the role of the federal government in the delivery of health services.

—To health planning agencies — develop a reasonable and workable plan for dealing with excess hospital beds, with opportunity for input by health professionals.

—To hospitals — make physicians more directly aware of hospital costs by periodically providing copies of the patients' bills or copies of costs of orders on a selected basis. Also, urge cooperation between hospitals for cost patterns which will allow for regionalized services — purchasing, lab work, etc., and

WHEREAS, this Report has received wide recognition in the news media and elsewhere, and

WHEREAS, we believe that wide dissemination of this Report will help in the fight against rising health care costs, now, therefore, be it

RESOLVED, that the House of Delegates of the Medical Association of Georgia hereby approves and heartily endorses the Cost Accountability Report of the Medical Association of Atlanta attached herewith.

REPORT OF THE COST ACCOUNTABILITY COMMITTEE OF THE MEDICAL ASSOCIATION OF ATLANTA

Approved by the Medical Association of Atlanta Board of Trustees, November 27, 1978

Committee Members

E. Napier Burson, M.D., Chairman
Mr. Peter Ackerson, Sears Roebuck Company
Mr. Bill Conlin, Medicare Division/Prudential Insurance Company
Mrs. Arthur Lee Cook, Atlanta Board of Education
* Richard DuBois, M.D.
Mr. Steve Egan, Fulton County Office
* Mr. John Gerlach, DeKalb General Hospital
Ms. Fay Glancz, Rich's, Inc.
Milton Goldman, M.D.
* Mr. Troy E. Hardin Jr., Troy E. Hardin & Associates
Mr. John Henry, Crawford W. Long Hospital
Mr. William N. Jenkins, Retail Clerks Union
Mr. Tom Kinser, Blue Cross/Blue Shield
Mr. Luther J. Maddox, Southern Bell Company
Mr. C. C. Martin, Trustee, South Fulton Hospital
Mr. Jeff Nalley, Lockheed-Georgia Corporation
Thomas R. Nolan, M.D.
Mr. Joe Reed, Cox Broadcasting Company
Mr. Douglass Richard, Medicare Division/HEW
A. Cullen Richardson, M.D.
Mr. Robert P. Surowiec, General Motors Corporation
Mr. Robert Youngerman, North Central Georgia Health Systems Agency

Introduction

In the Fall of 1977, a committee of members of the Medical Association of Atlanta was established to study and make recommendations and otherwise deal with the problem of escalating costs of health care. Recognizing that in the process of caring for their patients, physicians make most of the decisions which cause costs to be incurred, the committee was named "The Cost Accountability Committee.

The group's first efforts included reviewing cost containment activities of various local hospitals, and general discussions aimed at identifying areas of cost escalation where, through changes in procedures, new standards, or better communications, cost reductions, or control could be achieved. After several of these meetings, the Committee determined the need for information and viewpoints available only from outside the medical profession — from employers, the insurance industry, and from government agencies whose programs finance a substantial volume of the health care provided in the community.

This determination led to the expansion of the Committee to include representation of these other interests, and beginning on March 28, 1978, the group began the work resulting in this report. Since March, meetings of the full Committee, or of one or more sub-committees, have been held monthly.

The format of the report is a series of recommendations directed to:

(a) Physicians
(b) Patients
(c) Business, Labor, and Industry
(d) Third Party Payors
(e) Administration and Congress
(f) Health Planning Agencies
(g) Hospitals

It is recognized that one of the very major contributing factors to the cost of medical care today is the cost of care which derives from hospitalization of patients. Unnecessary hospitalization, surgery, treatments, or diagnostic and therapeutic procedures are to be deplored and not supported. The drain on the available health care dollar which occurs because of "over-utilization" could be very significant, and efforts to delineate these abuses if, indeed, they are occurring, are needed. Nevertheless, it is agreed unanimously that quality of health care must be maintained.

Other factors, such as empty or idle beds, staffed versus unstaffed beds, poor management, excessive capital expenditures, and other items relating to the general business of running a hospital, are recognized as factors in the cost of health care when they occur.

Once again, it is noted that meaningful input from all sectors responsible for the expenditure and utilization of health care dollars will be necessary for progress on cost accountability. The following recommendations are intended to achieve such input.

Recommendations to Physicians

1. Physicians should recognize that they are the key to the delivery of health care. Virtually all expenditures of health care dollars result from physician fees, orders, prescriptions, procedures, or hospital and nursing home stays which they have recommended.
2. Because of this key role in health care expenditures, physicians should assume a greater responsibility in the efforts to restrain demands placed upon the health care industry by patients.
3. Utilize, whenever possible, the full extent of diagnostic services which are available on an out-patient basis.
 (a) Patients needing hospitalization should be those patients in need of the care available in a hospital, rather than simply the diagnostic facilities within the hospital, since most diagnostic facilities are available to out-patients.
 (b) Pre-operative diagnostic studies can and should be obtained prior to hospitalization for elective surgical procedures.

* Sub-Committee Chairmen.

(c) Pre-operative consultations and/or second opinions can and should be obtained prior to hospitalization for elective surgery.

4. Physicians should organize their office staffs to allow for timely and efficient flow of patients, as well as information and reports concerning those patients, so that out-patient diagnostic services can be accomplished without undue delay.
 (a) Flow of accumulated information, in a timely fashion, into the hospital records, so that duplication of diagnostic studies at the time of subsequent hospitalizations will be performed only when necessary.
 (b) Efficiently run offices will allow physicians better capability for seeing patients when they are sick, instead of the need for an appointment with unreasonable delay. Such prompt attention would prevent otherwise unnecessary use of Emergency Room facilities.
5. Attempts should be made to improve communication between physicians, their staffs, and their patients, so that the patients will have better understanding regarding a physician's decision not to hospitalize a patient. This will also allay fears that the physician might not be available in the event a patient's condition deteriorates and hospitalization becomes necessary.
6. Distinct efforts should be made to schedule and arrange admissions to hospitals in a timely fashion. Admissions should occur on days when the hospital stay can be most effectively utilized. Whenever possible, avoid relatively non-productive weekend hospitalizations.
7. Similarly, discharges should be planned well in advance so that the patient and family can be notified regarding the plans and unnecessary prolongation of hospital stay for trivial reasons can be avoided.
8. Diagnostic tests and procedures should be organized and planned to avoid, whenever possible, emergency and "stat" procedures, which of necessity carry exorbitant add-on fees. Concentration and attention to these details on regular work day rounds could result in very significant savings of health care dollars.
 (a) Specify, when ordering, when the test should be performed. If it is not an emergency procedure, simply indicate, "in a.m.," so that there will be no confusion on the part of nursing staff when transcribing the order.
 (b) Specify, when ordering a "stat test," if the test should be drawn stat and performed stat or simply drawn stat, to be performed routinely the following day.
9. Whenever possible, order intravenous fluids, particularly hyperalimentation fluids, in advance, changing the orders only as an emergency, since reconstitution of these fluids cannot be performed; they must be discarded and new fluids prepared.
10. Specify that an apparatus, when discontinued, be



"removed" from the room when no longer needed. Such items as gastric suction, oxygen, hypothermia blankets, suction apparatus, etc., will generate a charge when sitting in a patient's room, even if not utilized.

11. Carefully evaluate all routine orders to delete cost-consuming, unnecessary procedures. Specifically, order a cancellation of routine orders when they are unnecessary for the given patient.
12. Review medications daily to be sure that unnecessary medications are not being used. This will avoid the expense of administration of the medications, as well as potential side effects and complications because of their use. Such complications and side effects, naturally, prolong hospitalizations.
13. Cooperate fully with the Infection Control Committee of your hospital, since these measures are designed to protect other patients, even though they might represent a burden to the infected patient. In turn, your patients will benefit from the cooperation of other physicians when their patients are the infected and isolated patients. Infection control needs everybody's cooperation.
14. Participate fully in all committees of your hospital and attend staff meetings. Become knowledgeable of the affairs and problems of your particular hospital and strive to correct the problems. Be sure that your committees are doing their work and that dollars are not being consumed because of inefficiencies and

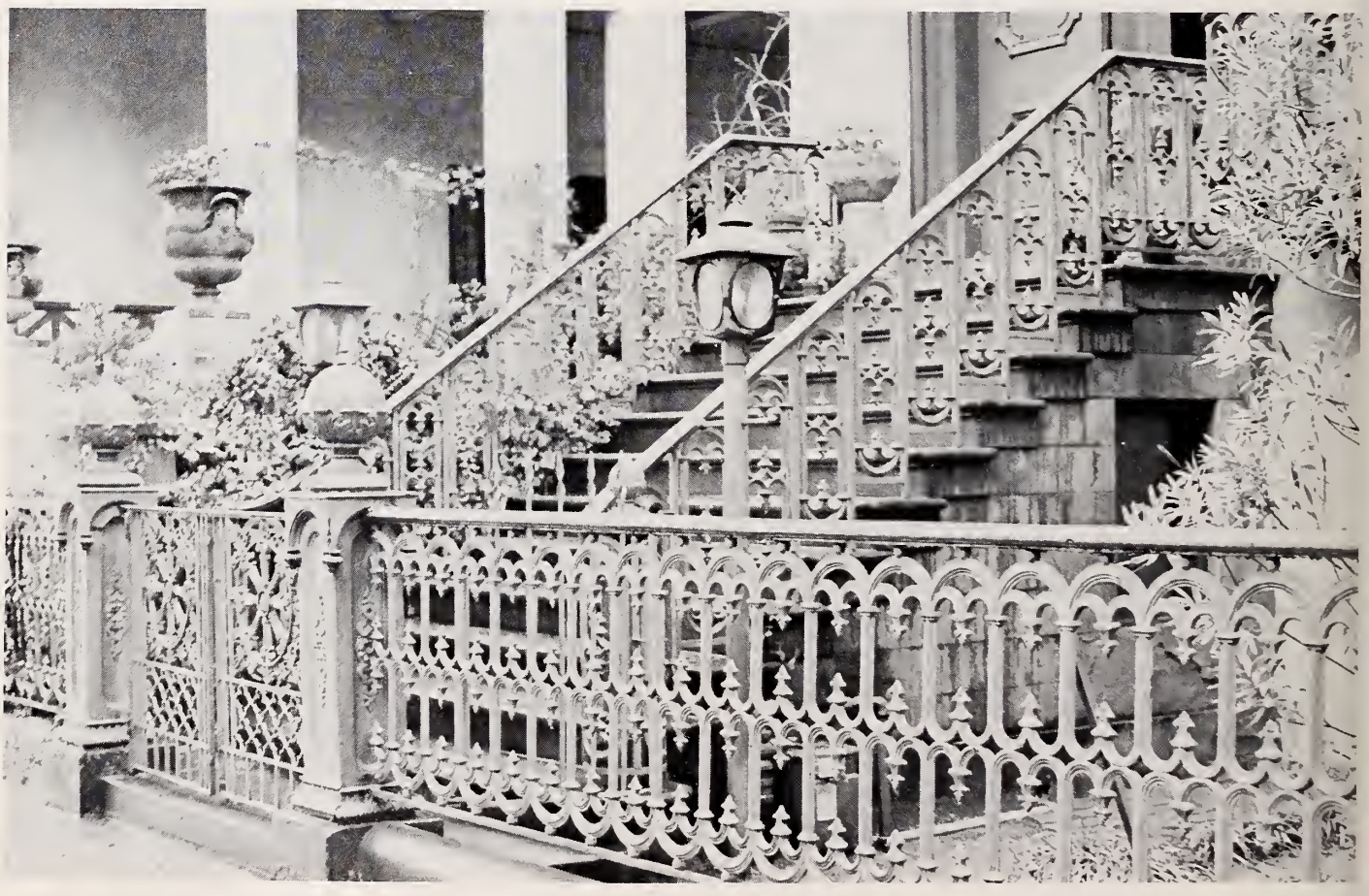
problems that exist only because there has been lack of attention. If you derive your living by practicing in a hospital, you have a moral and ethical obligation to contribute in the professional activities and committee work of the hospital staff.

15. Communicate with your patients. The best "defensive medicine" is a sound and solid doctor/patient relationship. Be available when they need you; listen to them when they talk to you; be polite to them and explain to them your diagnoses and your decisions and programs of therapy. The best patient care will occur when the physician cares about his patient.
16. When newer studies are developed to replace older studies, be sure that they do indeed replace the older studies and not simply supplement those older studies.
17. Solidify in your own conscience your position regarding the process of death and dying in your patients. Communicate this position effectively to families when appropriate, so that untold thousands of dollars will not be spent unnecessarily in a process of prolongation of death. It is possible that in the future courts of law will determine these decisions, rather than physicians and families. Nevertheless, communication between physicians and families will allow for full understanding of decisions which must be made and will decrease the likelihood of misunderstanding and subsequent litigation.
18. Cooperate fully with the local Health Systems Agency (HSA) regarding acquisition of high cost items for offices or clinics.

Recommendations to Patients (Consumers)

1. Just as the physician is the key man in the dispersal of medical care, treatments, procedures, and medications in and out of the hospital, the patient must realize that the physician responds to the needs and at times the demands of the patient. He is, therefore, at times in a vulnerable position, so it is the responsibility of the patient to avoid making unreasonable or untimely demands upon the physician for medical care.

 Do not make demands upon your physician for in-hospital diagnosis and therapy when he does not feel that it is necessary. It is the responsibility of all patients (consumers) to avoid unnecessary expenditures of funds whenever possible. It is immoral and unreasonable to triple or quadruple the cost of an evaluation by demanding that it be performed unnecessarily in a hospital just because "the insurance will pay for it."
2. Assume a greater responsibility and knowledge about your own health. Learn about health, disease, medications, treatments, and procedures, as well as the costs of these items. Even if insurance companies or the government pays for your medical care, it is



extremely important to realize that it is the public which provides the funds to meet these expenditures.
(a) Do not abuse your body or your health.
(b) Follow your doctor's recommendations.
(c) Take your medications as prescribed.
(d) Communicate without hesitation with your doctor. Do not be afraid to ask him questions.
(e) Do not take any medication unnecessarily.

3. Resolve marital, family, job, and other stresses through open communication and frank discussions. Unresolved stresses at home and on the job are a frequent cause of symptomatology which result in physician visits and diagnostic studies. Your mental health is important to your physical health.
4. Understand your health insurance. Read the policy carefully and discuss it with your employer and insurance representative. Many insurance policies differ in the quality and quantity of coverage, particularly regarding care administered in a hospital. Differences range all the way from maximum coverage to particular coverages, such as room rates.
5. Notify your doctor when you have been seen by another physician. Be sure that all of your physicians are in communication with each other, and request that they send reports to one another.
6. Do not hesitate to seek second opinions; but, when you do, be sure that your physicians communicate. On the other hand, do not "doctor shop"; that is, do not look for a physician who will diagnose your problem the way that you want to hear it or prescribe the type of medication that you are seeking.
7. Maintain a knowledge of your medical history, so that you know dates, procedures, physicians, treatments, medications, side effects, and diagnoses of previous illnesses.
8. Plan your discharge from the hospital with your doctor and do not prolong your hospital stay unnecessarily. If a member of your family is old, feeble, or frail and is in a hospital, plan with the physician for expedient discharge at the appropriate time. Do not request that the physician keep the patient in the hospital unnecessarily.
9. If you have a disability and there are benefits available for you, do not abuse or overuse these benefits just because, "I've been paying on this policy all of these years."
10. Do not abuse emergency room facilities. True emergencies only should be seen in emergency rooms. Non-emergencies should be seen by appointment in a physician's office.
11. Every patient should have a primary care physician; that is, a physician to whom they go for all of their symptoms. He can decide if referral to another physician is necessary. He will also help you choose another physician in whom he has confidence. If you have a physician, ask him if he is your primary care physician or if he deals with only one aspect of your health care. If he wants to limit his participation in your care, he will help you find a primary care physician, such as a family practitioner or a practitioner of internal medicine. If your physician cannot respond promptly when you have a serious problem, find yourself a primary care physician who can.
12. Do not place blind faith in your physician. He should be willing to discuss all of your questions with you. Do not hesitate to ask him questions. If he will not discuss your case with you, seek a second opinion.

Recommendations to Business, Labor, and Industry

1. Business, labor, and industry should communicate to employees that utilization of health services is an important factor in the cost of health care benefits. This issue could be discussed in internal meetings, house organs, etc. Programs on how to use health services should be organized in conjunction with health professional organizations.
2. Business, labor, and industry leaders should be active in community health affairs through participation on hospital boards and committees. They should voice their problems and concerns on costs and other issues to physicians and hospitals as much as is feasible. More communication and mutual understanding between doctors and patients is essential.
3. Business, labor, and industry should review their plans, programs, and policies on health coverage, disability, sick leave, etc., to ensure they do not encourage unnecessary use of physicians and hospitals.
4. Business, labor, and industry should cooperate with third party payors in efforts to explain insurance policy coverage to employees, particularly regarding deductibles, restrictions, and limitations.
5. Encourage labor, business, and industry to participate in the rehabilitation of employees by allowing earlier return to work and limited type of duty, rather than requiring the patient to return to full capacity work.
6. Adequate insurance should include coverage of outpatient services. Develop minimal standards for health plans.

Recommendations to Health Planning Agencies

1. Data utilized by health planning agencies in their planning efforts should be the most recent that is available.
2. Input from hospitals, physicians, and other health care providers should be solicited by health planning agencies as they develop their plans and criteria.
3. The health planning agencies should not recommend any additional hospital beds without a satisfactory justification on a regional basis.
4. The health planning agencies should develop a reasonable and workable plan for dealing with excess hospital beds in which opportunity is provided for health professional input into such development.
5. The health planning agencies should develop a reasonable and workable plan for regionalization of specialized services, in cooperation with health professional organizations, with such a plan designed to discourage duplication of services, facilities, and manpower. Such a plan should address the issues of utilization and categorization.

6. The health planning agencies should recommend approval of only those capital acquisitions subject to Section 1122 Review that meet reasonable need criteria, and which must be consistent with such institution's own long range plan, which in turn should be tied into the HSP of the local health planning agency.
7. Specifically encourage review and planning efforts to focus on alternatives to expensive in-patient care, such as home care, hospices, and various innovations in out-patient care.
8. Cooperate fully with physicians' offices, whether solo practice, group practice, or clinic, when they ask for advice or guidance regarding purchase of individual high cost items.

Recommendations to Hospitals

1. Implement a program of superior business management, utilizing up-to-date principles of industrial and personnel engineering, time and cost effectiveness, and avoidance of waste. Carefully scrutinize debt service, bed capacity, bed staffing, utilization, and fee structures.
2. Establish long-term plans and goals which are meaningful and realistic, recognizing that they are subject to change in the future. Accept physician and community input into all such long-term plans and goals, but apply good business sense to all programs and innovations.
 (a) Educate physicians and the community when requested programs, capital expenditures, or innovations are not cost effective or are duplicative. Do not fear being labelled "second class" if you do not provide services under these circumstances.
 (b) Establish a high level Budget and Planning Committee to establish priorities of all capital expenditures, so that accusations of favoritism can avoid a credibility gap.
 (c) Cooperate where appropriate with the local health planning agency for mutual sharing of facilities and programs.
3. Increase physician awareness periodically of the cost of hospital care by providing physicians with copies of his patient's bills or copies of the costs of his orders on a selected basis. Establish an on-going program in every hospital to inform physicians of overall hospital costs and the costs on their specific patients.
4. Every hospital medical staff should study not only quality but financial and utilization issues. Encourage your staff to identify and confront individual physicians with unusual utilization patterns. Analyze differences in the costs between physicians. Itemize which complications inflate the costs of care.
5. Encourage physician participation on all committees within the hospital structure. Establish effective lines of communication between committees, committee chairmen, and the Executive Committee of the medical staff. Disseminate information from committee reports. Eliminate waste and inefficiencies by promoting communication and recommendations which have proven to be effective. An administration representative should be present at all medical staff committee meetings. Administrative input is needed; response is necessary. Provide coffee at committee meetings, and let physicians know that you appreciate their time.
6. Be sure that committees are properly structured and run and that representation is good. Do not sustain redundant committees. Do not allow a committee's efforts to be wasted or unappreciated. Implement and support effective recommendations when generated from committees.
7. The Infection Control Committee is a crucial committee, since infections represent one of the most common and costly of hospital complications. Surveillance, educational, and preventive programs should be thorough and effective.
8. Activate a Cost Accountability Committee, support it, and implement a steady, ongoing, long-term program of cost containment, rather than a flash in the pan, one time, Ad Hoc Committee.
9. Direct attention regarding costs to physicians, nurses, and other employees.
10. Urge cooperation between hospitals for cost patterns which will allow for regionalized services — purchasing, laboratory work, etc.

Recommendations to Third Party Payors

1. All third party payors should encourage plan sponsors to adopt benefit packages which discourage excessive hospital utilization. Included should be deductibles and co-pay provisions which involve patients in the cost of the service, and out-patient coverage for laboratory, x-ray, surgery, and other services which can be performed effectively and with high quality on an out-patient basis.
2. All third party payors should conduct active programs of subscriber education in cooperation with business, labor, and industry, to inform them of their benefits and the cost of unnecessary and inappropriate use of ancillary services in understandable language.
3. All third party payors should conduct some type of review of the utilization of services by their subscribers. Concurrent or retrospective review of hospital and physician care should be encouraged.
4. Third parties should be more aggressive in identifying questionable or abusive utilization patterns or questionable or excessively high charges on the part of physicians and hospitals, and work jointly with foundations for medical care through educational or more stringent means to solve the problem.
5. Interaction between business, labor, and industry and third party payors should be full and frequent. Such interaction could lead to cooperation and more realistic benefit packages for long-term health care financing.
6. Instructions to each employee should be clear as to what insurance includes and does not include — in easily understood language.

Recommendations to the Administration and Congress

1. There should be no additional legislation or programs expanding health resources, services, or governmental reimbursement mechanisms until the areawide health planning process has been given an opportunity to take roots and inflationary pressures have been brought under more control.
2. Unwarranted utilization should be discouraged in the design of federal and medical programs.
3. Greater emphasis should be placed on more careful and effective health planning in order to allocate limited resources in a more efficient manner.
4. Existing federal initiatives which tend to expand the role of the federal government in the delivery of health services should be reviewed and evaluated for their effectiveness, and funded accordingly.
5. All V.A., military, and federal governmental health facilities should be subject to the local health planning process and review.
6. Reduce unnecessary regulations and documentation thereof.
7. Recommend a higher percentage of physicians to serve on HSA Boards.

REFERENCE COMMITTEE DISCUSSION AND RECOMMENDATION

Resolution 9 calls attention to the comprehensive report of a special committee of the Medical Association of Atlanta (MAA) on cost accountability. The report contains a number of recommendations addressed to physicians, patients, business and industry, third-party payors, the administration and congress, health planning agencies, and hospitals. It has already received publicity and dissemination on the national level. The resolution calls upon the MAG to consider the report of the MAA committee in drawing up any policy statement about cost containment.

Mr. Speaker, your Reference Committee D heard considerable testimony on the MAA report and its recommendations. It is obvious that the MAA committee has worked long and hard to produce its report, and we wish to commend the committee for it. Some of the testimony brought out that the MAA report does not address itself to causes of increased costs, such as inflation and government regulation, which cannot be appreciably changed by the efforts of physicians or consumers. Additional testimony found objection to some of the language in individual recommendations of the report. However, there was general agreement that the overall tenor was important and timely, and your reference committee feels that any MAG policy on cost containment should be based on documents such as this and the report of the MAG Statewide Conference on Cost Containment held last August. Consequently, your reference committee advises that the resolution be adopted.

HOUSE OF DELEGATES ACTION — Delegate W. Daniel Jordan moved that the resolution be amended to read "Resolved, that the House of Delegates of the Medical Association of Georgia recommend that the principles of the MAA Cost Accountability Report be considered in developing any policy statement about cost containment." This amendment was accepted by the vice chairman of the reference committee. On motion to refer this matter to the committee on cost awareness, the amended resolution was adopted and referred.

COMMITTEE ON HEALTH PLANNING

J. W. Chambers, M.D., Chairman

During the past year, the Committee on Health Planning has struggled but hopefully has still made some progress. At the meeting of this House last April, a resolution was approved instructing the Board of Directors to proceed with plans to develop task forces in each Health Systems Agency (HSA) area in the State of Georgia in order to attempt to disseminate more information to our own membership and to develop better cooperation and better communication with the various HSAs. At the June meeting, the Board of Directors in their wisdom delegated this responsibility to the Committee on Health Planning, and since that time we have attempted to carry out these instructions to the best of our ability.

This has been our primary activity during this year, but there have been activities other than that specific one. We have participated with the Legislative Committee in an advisory capacity for legislation that would affect the Medical Association of Georgia, in particular the Certificate of Need Law which was introduced into the State of Georgia Legislature in 1979. This Certificate of Need Law was not particularly desired by the MAG, but in the wisdom of the Legislative Committee and the Board of Directors, it was felt that in order for the State of Georgia not to run the risk of losing some $60 million in federal funds, the minimum Certificate of Need Law would have to be passed before 1980.

In addition, this Committee has attempted as best it could, with limited personnel and staff, to do a good job of monitoring the activities of the HSAs during this period of time. Pursuant to the June meeting of the Board of Directors, this Committee had a meeting in July 1978, at which time discussions were initiated as to how and what type of organization we should consider in setting up an organization which would fulfill the requirements as instructed by the House of Delegates. With the help of staff we attempted to determine just what had been done in other states in this regard. We found that relatively little had been done in most states, but that the State of Minnesota has set up an organizational apparatus which seems to potentially at least serve as a model to develop what we felt the House of Delegates wanted in this state. As a result of these discussions, we have during the remainder of this year slowly developed plans to attempt to set up task forces which would be representative of each county in each HSA. Hopefully, these task forces will be autonomous so far as each HSA is concerned, but all of these task forces should be coordinated by the Health Planning

Reference Committee D



Dr. J. W. "Red" Chambers speaks before the House.

Committee of the MAG. There has been much discussion, and to date two task forces have been organized.

By December 1978, it became apparent to this Committee that in order for all the task forces to be organized, knowledgeable, and function effectively, considerable added education would have to be done for our membership. As a result of this it was felt that the best way this might be accomplished would be a statewide meeting for representatives from each component society of this organization to be held in Atlanta. I, as your Chairman, appeared before the Board of Directors at its December meeting requesting funds for this purpose. This was referred to the Executive Committee for its discussion and decision. In February I appeared before the Executive Committee of the Board and they, after considerable discussion, provided funds for this meeting to be held as soon as time permitted.

We had originally hoped that this meeting could be held prior to the meeting of this House, but this proved to be unworkable. The possibility of having this meeting in conjunction with the Annual Session of this House was considered but was felt to be impractical by the Committee of MAG which has charge of the Annual Session. Finally, it was determined that Saturday, May 19, was the earliest possible date this meeting could be held. We hope that this will be reasonably convenient for those designated to attend by the component societies. However, at this point the Committee is encountering difficulties in getting component society presidents to name representatives to this meeting. Attendance at the meeting will be restricted to MAG members only and MAG staff.

Cooperative meetings with other organizations including the HSAs are envisioned, but this sort of meeting at the present time would be premature in our judgement. At the present time we are awaiting response from the component society presidents to provide the names of persons designated to attend this meeting.

I feel it my duty to report to this House that the biggest problem this Committee has encountered since its existence has been physician apathy. This applies not only to the legislation establishing the HSAs and the activities of HSAs, with the exception of a few key physicians, but also to the health planning process which seems to be foreign to many physicians' concepts. This Committee earnestly solicits the help of this House of Delegates in its efforts to overcome this apathy and to try to develop plans and programs which can effectively educate and interest our MAG members. We earnestly request that each member of this House attempt to help us to inform their membership in his own county and component society of the importance of the functions of these task forces.

I am pleased to report that staff for this Committee has been improved considerably since January 1 with the employment of Mr. Bert Franco, who is directly responsible for staffing this and other committees. He has been very valuable since his employment in attempting to develop these physician task forces. I would also like to express my thanks and appreciation to Mrs. Joyce Butler, who carried on under considerable difficulty with a rather considerable work overload in attempting to staff this committee along with many other committees prior to Mr. Franco's employment. I would also like to express my sincere appreciation to the Board of Directors and to the Executive Committee for their cooperation during this year.

The Committee submits the following recommendations for consideration by the House of Delegates:

1) That the Medical Association of Georgia continue to stimulate widespread physician interest in health planning through Physician Task Forces or whatever other means the physicians in each health service area deem to be appropriate for their health systems agency.

2) That the MAG encourage physicians already on HSA Boards to become more active in the activities of their respective HSAs and to encourage other physicians to become active in their local HSA.

3) That the House of Delegates express its opinion on the extent to which the Health Planning Committee should pursue its charge as stated at the June 1978 meeting of the Executive Committee and the Board of Directors of the MAG. This is as follows:

The Committee on Health Planning is charged to maintain liaison with local HSAs and with the State Health Coordinating Council (SHCC); to provide consultation and leadership to any local MAG-sponsored task force and the SHCC; to review legislative and regulatory activities and provide MAG with recommendations promoting the best interests of patients and physicians; and, further, is empowered to appoint a Task Force on the local level and, with the assistance of MAG staff, to set about creating a task force in each HSA area, the type of structure to be decided by the members in each HSA area.

It has been my pleasure to serve the association this year as chairman of this committee, and my sincerest appreci-

ation goes to members of this committee for their help. I shall be in attendance at the House of Delegates and hopefully the Reference Committee's meeting which will have this report and shall be happy to answer any questions which might be posed during that time.

REFERENCE COMMITTEE DISCUSSION AND RECOMMENDATION

Your reference committee read with interest the annual report of the Committee on Health Planning and wishes to commend the committee and its chairman, Dr. Red Chambers, on its challenging and often frustrating work of trying to get MAG members involved in learning about the HSAs and overseeing and participating in their activities. The report contains three recommendations.

The first recommendation is that the MAG continue to stimulate widespread physician interest in health planning through physician task forces in each health service area.

Mr. Speaker, your Reference Committee D is in agreement with this recommendation and advises that it be adopted.

HOUSE OF DELEGATES ACTION — Adopted the first recommendation of the Committee on Health Planning.

REFERENCE COMMITTEE DISCUSSION AND RECOMMENDATION

The second recommendation asks the MAG to encourage physicians already on HSA Boards to become more active in the activities of their HSAs and to encourage other physicians to become active in their local HSA.

Again, your Reference Committee D is in agreement and advises adoption of the recommendation.

HOUSE OF DELEGATES ACTION — Approved the second recommendation of the Committee on Health Planning.

REFERENCE COMMITTEE DISCUSSION AND RECOMMENDATION

The third recommendation looks to the House of Delegates for direction on the extent to which the committee should pursue its charge. Your reference committee heard considerable testimony about the importance of physician involvement in overseeing the activities of the HSAs and therefore wishes to make the recommendation that the committee be continued and that it proceed vigorously with its charge. In view of the importance of this entire subject and the upcoming statewide meeting to be sponsored by the committee, your reference committee wishes to make a further recommendation that each delegate of the House of Delegates be instructed to contact the president of his component medical society as soon as possible and to request the president to forward to the MAG with the utmost dispatch the names of those individuals who will represent that society at the Health Planning Conference to be held by MAG on May 19, 1979.

Mr. Speaker, your Reference Committee D advises adoption of the third recommendation of the Committee on Health Planning as amended by addition.

HOUSE OF DELEGATES ACTION — Adopted the third recommendation of the Committee on Health Planning as amended.

RESOLUTION 3
FUNDING FOR HEALTH SYSTEMS AGENCIES

Dougherty County Medical Society

WHEREAS, Health Systems Agencies (HSAs) were established by congressional action for the purpose of planning and distributing health care facilities and monitoring services, and

WHEREAS, the boards of directors of the HSAs, as legally constituted, have insufficient knowledge and experience to make the judgements required of them, directing in a sound manner the health care investments and activities of American society, and

WHEREAS, it is apparent that the public will be deprived of healthy competition and maximum benefit for tax money spent with continued operation of the HSAs and

WHEREAS, the money required for maintenance of the agencies alone is substantial, now, therefore, be it

RESOLVED, that the MAG inform the Senators and Congressmen from Georgia of the problems observed with the HSAs, and be it further

RESOLVED, that the MAG request the members of its Congressional delegation to vote to withhold further funding for HSA activities.

REFERENCE COMMITTEE DISCUSSION AND RECOMMENDATION

Resolution 3 alludes to several problems with local HSAs and their functioning and calls upon the MAG to inform the senators and congressmen from Georgia of these problems as well as requesting them to vote to withhold further funding for HSA activities.

Mr. Speaker, your Reference Committee D heard considerable testimony on the activities of the HSAs and believes that the MAG should express grave concern about the function and operation of HSAs. Your reference committee thinks that the resolution could be better worded by changing the final resolve as follows: RESOLVED, that the MAG request the members of its congressional delegation to review the effectiveness of HSAs before voting further funding. Mr. Speaker, your reference committee advises adoption of the resolution as amended by substitution.

HOUSE OF DELEGATES ACTION — Delegate J. Roy Rowland moved to amend the Reference Committee's amended version of the resolution by adding a third resolve: "And be it further RESOLVED, that since the existence of Health Systems Agencies is predicated upon the enactment of Certificate of Need legislation, the

Medical Association of Georgia actively work for the repeal of Certificate of Need which was enacted this year by the General Assembly of the State of Georgia.'' The resolution was adopted as amended.

RESOLUTION 16
PEER REVIEW/PSRO

F. William Dowda, M.D.

WHEREAS, the MAG Foundation has elected to become the PSRO, now, therefore, be it

RESOLVED, that the MAG activate the Peer Review Committee in order that a physician, for an administrative fee of $25.00, may request a review of his case with regard to medical propriety of the care and without regard to federal regulations and standards involved.

REFERENCE COMMITTEE DISCUSSION AND RECOMMENDATION

Resolution 16 asks that the MAG activate the Peer Review Committee so that a physician, for an administrative fee of $25, may request a review of his or her case with regard to the medical propriety of the care regardless of the federal regulations and standards involved.

Mr. Speaker, your Reference Committee D heard considerable testimony about the respective roles of the MAG Committee on Peer Review, the Georgia Medical Care Foundation, and the PSRO in the review of the medical propriety of cases submitted by physicians. Your reference committee begins by assuming that the MAG Peer Review Committee will honor any request by an individual member of the MAG to have his or her case reviewed for medical propriety. Such review appears to be an activity that the committee is already empowered to do, and the setting of a fee should be at the discretion of the committee. Your reference committee feels further that we should have confidence in the review mechanisms of the Georgia Medical Care Foundation and the PSRO to do the job capably until proven otherwise. For these reasons, Mr. Speaker, your reference committee believes that Resolution 16 is premature and advises that it be not adopted.

HOUSE OF DELEGATES ACTION — Delegate F. William Dowda moved that the words ''believes that Resolution 16 is premature and'' be stricken from the reference committee's report, and Vice Chairman Wells accepted this. The House voted to not adopt the resolution.

RESOLUTION 17
PSRO NATIONAL BUDGET

F. William Dowda, M.D.

WHEREAS, the federal government has established a federal regulatory agency called PSRO, and inasmuch as this activity is as yet of unproved benefit to the American people, now, therefore, be it

RESOLVED, that MAG request that the AMA adopt a neutral stance as to the inclusion of PSRO in the national budget each year.

REFERENCE COMMITTEE DISCUSSION AND RECOMMENDATION

Resolution 17 points out that the federal regulatory agency called PSRO is as yet of unproved benefit to the American people and therefore calls upon the MAG to request that the AMA adopt a neutral stance as to the inclusion of PSRO in the national budget each year.

Mr. Speaker, your Reference Committee D believes that this resolution makes sense and therefore advises that it be adopted.

HOUSE OF DELEGATES ACTION — Delegate Joseph P. Bailey moved that the resolution be amended to read ''RESOLVED, that MAG request that the AMA adopt a stance excluding PSRO from the national budget each year.'' The resolution was adopted as amended.

Vice Chairman Wells thanked the members who served on the reference committee and those who appeared before the committee to express their views. He also thanked staff for their assistance and advice.

Delegate William Collins rose to ask that the congratulations of the House be extended to Dr. Robert Wells, the newly-elected President-Elect of the American Academy of Orthopedic Surgeons. Congratulations from the House and the Chair were extended to Dr. Wells.



Dr. Frank Miller from Thomasville speaks to members of Committee C.



Committee C members include (L-R) Drs. Charles Rey Jr., Austell; A. D. Muse, Athens; Rupert H. Bramblett (Chairman), Cumming; John P. Heard, Decatur; and Hugo Moreno, East Point.

Report of Reference Committee C

RUPERT H. BRAMBLETT, M.D., Chairman

Chairman Bramblett reported that Reference Committee C met in the Pulaski Room at the DeSoto Hilton in Savannah on Friday, April 20, 1979, and thoroughly examined and carefully considered all items referred to that committee.

Members of the Reference Committee present included Rupert H. Bramblett, M.D., Cumming, Chairman; John P. Heard, M.D., Decatur, Vice-Chairman; Eloise B. Sherman, M.D., Savannah; Charles J. Rey Jr., M.D., Austell; A. D. Muse Jr., M.D., Athens; and Hugo S. Moreno, M.D., East Point.

REPORT OF FIRST VICE-PRESIDENT

L. Newton Turk III, M.D.

The MAG has come through another year, bloodied but nearly unbowed by attacks on many fronts. Internal discord, member apathy, and organizational inertia have had to be overcome sometimes before the real issues could be attended to. The MAG has been able to muster an often acceptable and occasionally brilliant response to many of its challenges. Its overwhelming burden of activity continues to be in reacting to external events and contingencies at which it has been surprisingly successful after a good bit of practice. The organization, in my opinion, badly needs to move beyond this realm of reaction into initiative with forward planned, goal-oriented pursuits in order to reach its full potential.

Participation in the selection of the organizational goals should provide for the members both a strong unification of purpose and a greater sense of identification with the MAG. This cannot be done with one stroke, but requires time and concentrated effort on the part of the leadership and staff, and a great deal of support from the membership. It should be started now. To that end, I recommend the following:

RECOMMENDATION

1. That a long-range planning committee be activated by the MAG.
2. That this committee be charged by the House of Delegates to propose goals for the organization, priorities among those goals, and outline suggestive pathways and time frames for achievement of the goals.
3. That this committee be expected to seek idea input from the membership, from the leadership, staff and external organizations, and individuals in its deliberations.
4. That this committee make its initial report to the House of Delegates annual meeting in 1980 and at least every 2 years thereafter.





Drs. L. Newton Turk III, Joe C. Stubbs, and Frank Miller during committee discussions; committee members Hugo Moreno and Eloise Sherman.

REFERENCE COMMITTEE RECOMMENDATIONS:

Officer Report 4 and Recommendation 2 of Officer Report 6 were considered together. Both First Vice President L. Newton Turk III, M.D., and Chairman of the Board, Joe C. Stubbs, M.D., expressed extreme urgency and concern that the Medical Association of Georgia, in order to reach its full potential, have a strong unification of purpose established with published goals and priorities to be carried out effectively and expeditiously by the leadership of the organization and by the MAG staff.

RECOMMENDATION

Mr. Speaker, your Reference Committee agrees totally with the concept of the officer reports of the First Vice President and Recommendation 2 of the Annual Report of the Chairman of the Board of Directors. However, Mr. Speaker, your Reference Committee advises that the original recommendations 1, 2, 3, and 4 of the Annual Report of the First Vice President and Recommendation 2 of the Annual Report of the Chairman of the Board of Directors be not adopted and recommends adoption of the following substitute Recommendations:

1. **A special "blue ribbon" Planning Committee should be immediately appointed by the Speaker of the House of Delegates to be instructed to do the following:**
 a. **Propose goals for the organization, priorities among those goals, and outline suggestive pathways and time frames for achievement of the goals.**
 b. **Report quarterly to the Board of Directors and annually to the House of Delegates.**
 c. **Consider the appropriateness and economic feasibility of obtaining outside professional assistance in this study, presenting this finding and recommendation to the Board.**
 d. **Study the organizational structure of MAG with its present Officers, Board of Directors, and 49 active committees and consider the efficiency with which the structure can function in obtaining our projected goals.**
 e. **Study the existing staff, its quantity and qualifications for accomplishing the goals and priorities of the organization.**
 f. **Study the MAG needs to remain in its present physical plant or make recommendations for a new expanded facility.**
2. **The Executive Committee is challenged to immediately establish goals and the assignment of priority to these goals with said goals and priorities reported to the Board as soon as possible.**
3. **This "blue ribbon" committee and the Executive Committee are requested to work closely to assure that both the short-range and the long-range goals for the Association are realistic, obtainable, and for the overall benefit of the physician members of the Medical Association of Georgia and the health care of the citizens of the state.**

HOUSE OF DELEGATES ACTION — Voted to not adopt recommendations 1, 2, and 3 of the Reference Committee report.

REPORT OF THE CHAIRMAN OF THE BOARD OF DIRECTORS

Joe C. Stubbs, M.D.

The Board of Directors of the Medical Association of Georgia and its Executive Committee are the working arms of organized medicine in our state. Composed of 36 Directors and Alternate Directors representing all geographical areas of the state, plus officers, AMA delegates and alternates, and past presidents, the Board meets regularly with good attendance. Staff members and guests often swell the attendance to 70 to 80 people at each meeting.

During the two terms that I have served as Chairman of the Board, many subjects have been discussed and many decisions have been made. Yet when I sit back and reflect upon our accomplishments, I sometimes feel we have fallen short of our primary obligations which are so aptly stated in our Constitution and Bylaws — we are dedicated to lead a great organization, to promote the provision of quality medical care at reasonable cost; to encourage the maintenance of the physician-patient relationship as an

essential to the delivery of quality care; and to assure all Georgians access to quality medical service regardless of their financial condition. It is also our obligation to assure adherence to the highest standard of professional conduct by our members. Simply put, the purpose of our Association is "to promote the science and art of medicine and the betterment of public health."

Voluminous reports on agenda items are mailed out to members in advance of the Board meetings. These reports are reinforced with long discussions at the meetings, presented primarily to provide Board members with sufficient background information upon which to make major decisions. Items requiring more detailed study are referred to appropriate committees with directions to make in-depth studies and report back to the Board with recommendations for the Board's action. More often than not the work of good committees is rehashed by the Board, resulting in the Board's functioning as though it were the committee of primary jurisdiction. Likely as not, reports will then be accepted for information rather than any definitive action being taken by the Board. This not only represents a duplication of effort — with the Board repeating what the committee has already done — but results in long, laborious, and tiring meetings — the precedent of our organization for many years. If, after each meeting, one would reflect upon exactly what was accomplished towards the stated purposes of our Association, we would be hard put to explain it. For the time and effort expended by members of the Executive Committee and Board, more concrete results should have been obtained. The Board must take steps to correct this situation if we are to adequately serve our membership and strive to achieve our purpose.

It is true that during the past year of meetings we have accomplished some good. We have made major decisions in the area of health planning. We have established our policy on second opinions, discussed the advantages and disadvantages of consumer representation on various state boards, and resolved the separation of the Georgia Medical Care Foundation from the control of MAG by the establishment of a statewide PSRO.

We have seen our staff endeavor to meet the requirements of our growing organization, with increasing state and federal agency involvement in the private practice of medicine — a staff that is far too small, spread too thin to meet increasing demands, working in inadequate quarters, and frequently feeling themselves to be the target of unjustified criticism growing out of the frustration of some of our members with federal and state encroachment upon private practice. In addition to attending meetings of the Executive Committee and Board of Directors, our staff must attend multiple meetings of the 50-odd MAG committees, compiling all the background data needed for presentation of relevant matters to the Board.

Another concern both readily apparent and easily documented is that of rampant apathy on the part of our district medical societies. Without exception, meetings of district societies are poorly attended and no longer serve the purposes for which they were created. Interest generally is at an all-time low, and there are very few of our members who have any concern for the continued existence of the district society as a structural part of the total MAG organization.

Were it not for the fact that district medical societies are the mechanism through which Directors and Alternate Directors of the Board are elected, it would make very little difference if they continued to exist or not. However, I believe we must recognize that we have a serious problem in the fact that only a handful (as few as 20 in some districts) of physicians attend district society meetings and participate in the election of Directors and Alternates. If we continue to elect our Board members by this out-of-date method, our problem will remain with us. We should discontinue holding important elections under circumstances that we know to be out of favor with the overwhelming majority of the members of a given district society.

Several years ago an unsuccessful effort was made to develop a system by which all Directors and Alternates would be elected by mail ballot sent to all members of each given district medical society. Under that plan the presidents of the various county medical societies throughout the district would have acted as a nominating committee. This plan was not acceptable to the House of Delegates at that time.

The time has come, however, when the House should consider the logic and weigh the merit of working out a system under which the House would elect members of the Board of Directors. This could be done with relative ease by amending the Bylaws to authorize the Delegates and Alternates on a district-by-district basis to act as electors at a district caucus during the Annual Session. A special time could be set aside for this purpose. There are several obvious advantages to this system. First, it would greatly increase the number of physicians who participate in the election and virtually guarantee that a voice from every county in the district would be heard. The level of awareness of matters confronting the Board, the House, the Association, and perhaps the entire profession is generally greater among the members of the House of Delegates than it is apt to be among the rank and file of the membership. Thus the electorate is better informed and would be presumed to cast a more informed vote. In addition, this process would make the Board of Directors directly answerable to the House which, under our present system, it is not. It should be remembered that the Board of Directors implements the policies of the House and functions throughout the year as the "representatative" of the House with full authority in all matters. In view of this, it would seem prudent to alter our system.

Under our current method the House elects all members of the Executive Committee except the Chairman of the Board. Of course, the Executive Committee is a part of the Board of Directors.

The activities of the Board itself could be streamlined by enhancing standing committees with strong membership and leadership within the committees. An in-depth study would probably reveal that many of our present

committees serve no useful purpose, do little towards carrying out the charge of the committee, and produce few effective recommendations to our Association. This brings us back to the need to expand our present staff. Many functions of committees could be accomplished with greater ease and efficiency by expanding our present staff. Detailed studies of problems that occur over the state could be documented by onsite visits by staff. Information of the type and depth needed for the Board to make intelligent decisions is not readily available and seemingly could be gathered only by the above method. By contrast, the busy physician-committee-member is unable to free himself from the constraints of his practice to spend the time necessary to gather needed data.

A prime example of this weakness is demonstrated by poor physician attendance and apathy toward Health Systems Agencies, resulting in lack of advance knowledge of what is occurring in these areas. Here we have an organization within our state that is directly affecting the physician-patient relationship and quality of care. Whether its work is good or bad is no excuse for the fact that we are not constantly monitoring every recommendation made within these groups so that, through our influence, we can exert positive control on recommendations and policy-making. Only through an expanded, experienced staff can this possibly be done.

Another area of our obvious weakness is our inability to cope with the ever increasing government agencies, both federal and state, being established throughout our state in the form of rural health clinics, National Health Corps physicians, nurse practitioners, and others. We should know exactly what is occurring at each site, precisely the opinion of local physicians towards these government programs, exactly what type and quality of medicine is being practiced, and whether it is adversely interfering with the private practice of medicine in our state. We should, at the same time, be able to accumulate sufficient data to demonstrate to the government the usual high cost of its various programs.

Last but not least, it is becoming more and more apparent that we need to establish long-range policies and goals that would enable our leaders to place priorities on the work and function of our organization as well as upon the staff. This cannot be accomplished easily, but a beginning can be made by holding an intensive conference on this one subject, inviting experts in these areas to guide us. We could slowly develop long-range policies that could be easily followed by the working Board of Directors and Executive Committee. The areas of greatest concern are related to budget. How effectively are our monies being spent? Is our staff being overburdened with multiple requests and projects, resulting in interference with the stated purposes of their jobs? Staff is being spread too thin and is increasingly aware of this fact and concerned that it is not accomplishing what it is being paid to accomplish.

One of our greatest areas of influence is that of legislation. There is no doubt in my mind that we are one of the most influential organizations within our state, but frequently our activity at the legislative level is weakened by a lack of priorities. Policy is not sufficiently defined to give the Legislative Committee and staff direction. We must at all times remember that in the legislative area our purpose is to protect the patient-physician relationship and the private practice of medicine. We must not permit the desires of isolated groups within our own membership to destroy our effectiveness. We are obviously more effective at the state level of government because of the proximity of the Legislature but there is no reason why our same talents and effectiveness cannot be projected at the national level. It is embarrassing, to say the least, when an officer of our Association communicates with a member of our Congressional delegation concerning a major problem and gets an answer dealing only in generalities and which, in fact, constitutes nothing more than an appeasement of a previous complaint.

It is time for our Association to realize that the way we have functioned in the past is no longer effective. A new approach is needed to continue the strength and force for good of a very great organization.

RECOMMENDATIONS

1. Refer to the Board of Directors the matter of election of Directors and Alternate Directors with direction that this be studied in depth and should the Board conclude that the plan has merit, instruct the Constitution and Bylaws Committee to prepare the appropriate amendments for presentation to the 1980 House of Delegates meeting.

2. The Board of Directors should be requested to develop a process through which it would identify goals and objectives of the Association and to establish priorities for both long range and the short term. The Board should report to the House on a regular basis on its activities and progress in this endeavor.

REFERENCE COMMITTEE DISCUSSION

The report of Officer 6, Recommendation 1 refers to the logistic problems of district medical societies within the MAG obtaining participation of all physicians within that district as to the election of directors to the MAG from that district.

Much was said as to the lack of attendance at district medical society meetings and to the lack of involvement of physicians in the district society to have input to the election of directors from that district. Some thought the system currently in existence was extremely good, while others thought there was a continual decline of interest and activity at the district medical society level. All agreed that a mechanism needs to be devised to increase the attendance and participation of all physicians at the district society level. The members of this Reference Committee, acknowledging this, agreed that new ideas and approaches need to be devised and possibly implemented by the next House of Delegates.

RECOMMENDATIONS

Mr. Speaker, your Reference Committee advises Recommendation 1 be not adopted and advises adoption of this substitute recommendation:

1. That the matter of devising alternatives for input and election of directors to the MAG district level be referred to the Planning Committee to be appointed by the Speaker of the House and if, in the minds of this committee, alternatives have merit, then those alternatives shall be communicated to the Constitution and Bylaws Committee with suggestions that they draft appropriate amendments to be presented to the 1980 House of Delegates.

HOUSE OF DELEGATES ACTION — Voted to not adopt Recommendation 1 of the Report of the Chairman of the Board of Directors or the Reference Committee's substitute recommendation. The House then voted to adopt Recommendation 2 of the original report of the Chairman of the Board of Directors.

COMMITTEE ON CANCER

J. Moultrie Lee, M.D., Chairman

The 1978 MAG House of Delegates recommended that the MAG continue to support the Governor's Cancer Advisory Committee. In following out this recommendation, the MAG Cancer Committee met to determine what programs the Governor's Cancer Advisory Committee was advocating and what recommendations this committee should make to the MAG concerning those programs.

The Governor's Cancer Advisory Committee is recommending that a community-based, complete cancer program be established. The nucleus of this program is to be a Medical Director at each facility. The present State Aid Cancer Program has 18 clinics (tumor clinics). This number should be expanded to 25 facilities, each with its local Medical Director. The present 18 Medical Directors are all voluntary and serve without pay. The additional six will hopefully do the same. In addition to the Medical Director there would need to be a full-time Nurse Coordinator at each of the 25 facilities.

The 18 facilities now existing throughout Georgia are diagnostic and treatment facilities. Expansion of this program will give the possibility of increased preventive measures, earlier detection of cancer, earlier and more effective treatment of cancers, increased use of outpatient management, better rehabilitation of cancer patients, more public and professional education about cancer, and expanded and better coordinated use of volunteer services.

There are now an estimated 13,000 new cases of cancer per year in Georgia (1,820 medically indigent). A total of 21,409 cases are presently under treatment (8,827 medically indigent). State expenditures per year for state aid patients and the cancer registry is $1.6 million. Expansion of the program as is being requested would add an additional cost of less than $450,000.

Over 90% of the present funds appropriated for cancer is needed and used for treatment. Less than 10% is available for the important areas of prevention, early detection, public and professional education, and rehabilitation. Furthermore, the program relates almost entirely to the medically indigent and not to the private sector.

The six additional facilities advocated will be so located that all the citizens of Georgia will have access to skilled cancer care.

The 25 Nurse Coordinators will train other nurses in the special techniques of cancer nursing, counsel and support cancer patients and their families, and instruct patients in early rehabilitative measures. They will work closely with private physicians and their patients as well as visiting in the State Aid Cancer Clinics. They will have many additional duties in instruction, prevention, detection, and reporting.

A central office will be provided to aid physicians by developing guidelines for the accepted methods of treatment. It will collect and analyze data from each community program, coordinate the 25 facilities, and provide a statewide picture of the cancer problem in Georgia.

The proposed community-based program will bridge the gap between the State Aid Program for the medically indigent and the management of private cancer patients by their physicians primarily by the functions of the Nurse Coordinators.

RECOMMENDATIONS

1. The MAG Cancer Committee unanimously recommends that the MAG support the community-based cancer program proposed by the Governor's Cancer Advisory Committee.

2. At the present time, funding for the State Aid Cancer Program is a portion of the Department of Human Resources budget request. The MAG Cancer Committee recommends that the MAG support the Governor's Cancer Advisory Committee in this budget being considered as a separate entity from the Department of Human Resources in its budgetary request.

3. The Central Cancer Tumor Registry is not adequately funded by the Department of Human Resources. The MAG Cancer Committee recommends that the MAG support the Governor's Cancer Advisory Committee in obtaining adequate funding for said Tumor Registry from the Department of Human Resources.

The 1978 House of Delegates also recommended further investigation by the MAG into the Cancer Information Service Program. The spread of the Cancer Information Services Program into Georgia has apparently taken place by federal directive by WATS line, and therefore no action is needed by MAG.

The Chairman wishes to extend his deep appreciation to the members of the committee for their invaluable aid, interest, and cooperation throughout the past year.

REFERENCE COMMITTEE DISCUSSION

Committee Report 10 requests that MAG support the community-based program as proposed by the Governor's Cancer Advisory Committee and asks the MAG to support line-item budgeting through the Department of Human Resources for the State Aid Cancer Program.

Recommendation 3 of this report was accomplished by legislative edict during the 1979 legislative session, therefore your Reference Committee is deleting that Recommendation.

RECOMMENDATION

Mr. Speaker, your Reference Committee advises adoption of Committee Report 10 as amended by deletion of Recommendation 3.

HOUSE OF DELEGATES ACTION — Adopted the report of the Committee on cancer as amended by the Reference Committee (which deleted Recommendation 3 of Cancer Committee report).

MEDICAL PRACTICE COMMITTEE

W. Dan Jordan, M.D., Chairman

In its meetings in the past year the Medical Practice Committee has addressed three major topics.

I. Canadian Physicians

The committee discussed a report by the Georgia Academy of Family Practice that studied the problem of a state regulation requiring one year of residency in the State of Georgia before a Canadian physician could obtain a license to practice. In view of the status of medical education in the Canadian schools, the apparent desire of Canadian physicians to migrate to the United States, and the publicity concerning the need for more physicians in this state, it was recommended that the Medical Association of Georgia support the position of the Georgia Academy of Family Practice in requesting that the one year residency requirement for licensing Canadian physicians be discontinued.

II. Rural Health Clinic Survey

In response to Resolution 12-78 the Medical Practice Committee was charged by the Board of Directors to investigate the feasibility of undertaking a statewide evaluation of the primary care delivered by the various primary health care centers over the state. In accordance with the apparent feeling on the part of MAG physicians that the care was less than optimal, a survey questionnaire was devised to obtain the necessary information. This was mailed to the component medical societies in order for the local physicians to supply the raw data concerning quality, continuity, and cost of medical care delivered at the local level. Only 21 of the local groups responded, representing 43 various types of clinics. The overwhelming majority of the data appeared to have been supplied by the local public health department. Apparently this had resulted from the local societies referring the questionnaire to the local health department to obtain the requested information. The results of the survey were summarized, but the data was felt to be so inadequate that a telephone survey of the remaining societies was conducted. Despite an occasional report of an unsatisfactory local situation, the committee decided that there was insufficient information to arrive at a valid conclusion. The committee recommended to the Executive Committee of the Board of Directors that should local physicians express their concern about the quality and/or cost of medical care delivered by the local primary health care clinics, the committee should then be allowed to utilize whatever means that were reasonable and appropriate to investigate those same complaints, noting that the investigation might require additional funding.

III. Health Maintenance Organization-Individual Practice Association (HMO-IPA)

The Medical Practice Committee was directed by the Board of Directors to monitor the development of HMOs throughout the state and report to the House of Delegates at the 1979 session. This was later modified to include investigation of the HMO-IPA concept and its impact on the physician-patient relationship, as well as developing a position statement on the HMO-IPA concept.

A. Background

The committee requested written information from each of the known HMOs in the metropolitan Atlanta area and invited Justin Myrick, Ph.D., to present general information regarding HMOs, IPAs, and their relationships to each other. (Dr. Myrick is Associate Professor of the School of Health Systems at the Georgia Institute of Technology. The School looks primarily at organization, management, and evaluation of health delivery systems.)

Dr. Myrick explained that an HMO is basically a prepaid health care company. There are three different types of HMOs established by law. All HMOs must offer a basic comprehensive program including preventive medicine in order to be qualified under federal law.

1. The group model is a centralized group of physicians which offers a coordinating program of medical benefits from a centrally located office, clinic, or hospital, the physicians being employees within a group that supplies medical services to an HMO.

2. The staff model is similar to the group model except that the physicians are salaried employees of the HMO which also provides hospital services.

3. The IPA is an organization of physicians who coordinate in order to offer a comprehensive program. There is no centralized medical facility. The physicians practice in their own offices with the HMO patients as possibly only a percentage of their total practice. The patient/member may choose the individual physician and/or select from the facilities that are retained by the HMO-IPA contractual relationship.

Based on 1977 data, Dr. Myrick reported that there are 6.3 million people enrolled in 165 HMO plans (a 5% increase over 1976). Of the 6.3 million, 70.6% are in HMOs which have been in existence over 10 years. Sixty-five percent of the plans and 90% of the patient/members are in group practices. Because of the current federal initiative for the development of HMOs, Dr. Myrick felt that physicians could interpret this as more federal intervention and one step toward socialized medicine. Conversely, it was his opinion that the HMO-IPA

concept may be the only way left to stop the federalization of medicine. One of the reasons the federal government is interested in HMOs is their record of reduction in the length of hospital stay. For example, 1977 statistics reflect the average hospital days per 1000 population for all HMOs is 488/1000, compared to nation-wide figures of 700+/1000 and the Atlanta Blue Cross figures of 1026/1000.

Dr. Myrick also discussed the physician-related advantages and disadvantages of an IPA. Generally speaking, the disadvantages might be:

1. Set fee structure (determined by the physicians in the IPA).
2. Control of hospital utilization. All successful HMOs have some form of hospitalization review. The most successful have some form of prior approval for elective admissions (developed by the IPA).
3. Physicians are at risk in an IPA since there is a set amount of money available to take care of a certain number of patients. Generally, after setting the fee allowance, the physician will agree to accept a percentage of his fee with the remainder used for a contingency fund in the event utilization projections are inaccurate.

Some advantages to the physician are:

1. Guaranteed payment within 30 days.
2. The forms are simpler than filing insurance claims.
3. If your patients join an HMO, you will not necessarily lose them.

Dr. Myrick discussed a now successful plan established in the Minneapolis/St. Paul area under the aegis of the local medical society. This action was taken by the medical society to enable physicians to counter the loss of patients to the HMO in the area. Under the law governing the HMOs, all employers who have more than 25 employees must offer their employees the option of HMOs, as well as their current insurance, provided a federally qualified HMO is available. The employee can elect not to participate, but the employer must offer the options.

B. Current HMO Activities

The committee determined that all HMOs have the following features in common.

1. Prepayment by subscriber (patient and/or employer).
2. Hospitalization utilization controls in the operation of a successful HMO.
3. Accepted physician fee controls.
4. Physician bills plan instead of patient.

The committee determined that there are five activities related to HMOs in the metropolitan Atlanta area. There are three HMOs in various stages of development including application for federal funds within the urban area; another is being proposed in the Coweta County area, and a marketing survey in the metro Atlanta area is being conducted by Dykewood Industries of New Mexico. The HSA directors in other areas of the state report no positive activity, although there is discussion about this in some areas.

The recently passed HMO law in Georgia allows for the formation of HMOs as separate entities, without requiring the same reserves that an insurance company must maintain. The requirements under the law are also such that each HMO can meet federal qualifications standards without difficulty. To our knowledge those developing will also be seeking federal qualification in order to secure federal funds. The committee will continue to monitor the development of these various HMOs and report to the Board of Directors or the House of Delegates as time should seem to indicate.

C. Impact on Physician-Patient Relationship

The committee readily recognized the adverse impact of a staff or group model HMO, since the subscribers are required to utilize only those physicians employed by the HMO. This directly limits the patient's choice of physician, although the patient obviously has the choice of joining or not joining the HMO itself. The staff model employs the physicians directly. The group model provides care through a group which commonly must spend at least 35% of their time treating HMO subscribers, so physicians are frequently limited in their practice.

The IPA is a legal entity organized and operated by physicians who continue to practice in their own offices. The impact on the physician-patient relationship is much more subtle in this concept. This occurs because a successful HMO-IPA requires strict utilization control, accepted fee controls, and risk-bearing by the physician. It is these economic factors that tend to shift patient decisions to physicians and could create situations resulting in rationing of care. The committee listed the following advantages and disadvantages of physician involvement in an IPA.

Advantages:

1. Guaranteed payment.
2. Simplification of forms.
3. Possible practice protection.
4. Deterents of development of group and/or staff model HMOs.

Disadvantages:

1. Set fee structure (by the IPA).
2. Necessity to perform utilization review beginning with control of hospitalization but probably including pre-admission certification.
3. Risk-bearing:
 a. Financial — 10 to 20% taken from the established fee is usually set aside in a contingency fund in the event utilization projections are inaccurate.
 b. Liability — the possibility exists that operating under the guidelines of an HMO-IPA, a physician might become involved in a malpractice situation.
 c. Due to the economic factors involved there is a shifting of decision-making process from the patient to the physician.

Because of the contractual requirements of an IPA, it is imperative that any physician involved with an IPA be very aware of such legal implications as:

1. Physicians must be fully aware of
 a. Implication of risk-bearing, and
 b. Shift of decision-making process to the physician.

2. Individual physicians be protected against IPA corporate liability in questions of:
 a. Membership of incompetent physicians,
 b. Peer review activities,
 c. Utilization review activities.

There is a widespread assumption that the development of HMOs will reduce costs. The committee felt that the evidence reflecting the impact on costs was conflicting. Unfortunately, there was no information available concerning the problem of patient overutilization.

D. Position Statement

The following statements were developed by the committee and referred to the Board of Directors for their consideration.

1. That MAG support the concept of neutral public policy and fair market competition among all systems of health care delivery.

2. That MAG and/or its subsidiaries not now develop an IPA as advantages do not appear to outweigh the disadvantages.

3. That the development of local IPAs be viewed with caution because of the above listed disadvantages.

4. That MAG offer to assist locally developed IPAs in eliminating or minimizing the above disadvantages.

At its January 1979 meeting, the Board of Directors failed to adopt the above policy, thus reverting to the previous position adopted at the June 1978 Board of Directors meeting which is as follows:

The MAG is opposed to the development of an IPA-HMO by this organization at the present time due to the adverse impact such a delivery system has on the doctor/patient relationship.

IV. Recommendations

1. That the MAG support the removal of legal residency requirements for Canadian physicians to obtain a Georgia license.

2. That the Medical Practice Committee be responsive to inquiries concerning inadequate care in Primary Health Care Clinics by thorough local investigation. (See fiscal note.)

3. That the Medical Practice Committee continue to monitor the activities of HMOs throughout the State of Georgia.

(Fiscal note — Funding for investigation of this type cannot be projected without having more specific circumstances of a complaint. It is possible that it could result in expenditure of several thousand dollars.)

REFERENCE COMMITTEE DISCUSSION

Committee Report 26 is a well thought out and professionally written report which deserves the careful consideration and perusal of each and every member of the MAG.

This report asks the MAG to support removal of residency requirements for Canadian physicians to obtain a Georgia license. Discussion brought out that the MAG Board of Directors was already on record as approving legislation, House Bill 599, introduced in the 1979 Georgia Legislature, to remove the legal residency requirements for persons graduating from approved Canadian medical schools to obtain a Georgia license. This Reference Committee thought this verbiage was better than that of the original Recommendation and therefore amends Recommendation 1 to read as follows:

1. That the MAG support the removal of legal residency requirements for Canadian physicians who have graduated from approved Canadian medical schools to obtain a Georgia license.

Recommendation 2 of this committee report requests that the Medical Practice Committee be responsive to inquiries concerning inadequate care in primary health care facilities by thorough local investigation. It was brought out to the committee that currently MAG staff has been assigned the responsibility to investigate on an on-site basis the rural health care clinics proposed and operational, both by the Department of Human Resources, other federal and state agencies, and individual physicians operating satellite offices.

Recommendation 3 of this committee report asks the MAG Medical Practice Committee to continue to monitor the activities of HMOs throughout the State of Georgia.

RECOMMENDATIONS

Mr. Speaker, your Reference Committee advises adoption of Recommendation 1 as amended and advises adoption of Recommendations 2 and 3.

HOUSE OF DELEGATES ACTION: Voted to adopt Recommendation 1 of the report of the Medical Practice Committee as amended by the Reference Committee and adopted Recommendations 2 and 3 of the original report as presented.

The Report from Committee C is continued in the Third Session of the House of Delegates, p. 623.

Auxiliary Highlights





(Round photo): Irene Glucksman (Mrs. Michel), from St. Simons, is the new President of the Auxiliary of the MAG.



(Above — L-R): Irene Glucksman, Sandee Carter, and Millie Northup. (Left photo — L-R): Irene Glucksman; Nony McMichael (Mrs. Robert), from Macon, now the immediate Past President; Sandee Carter, Savannah; Pat Fine (Mrs. Robert), member of the DeKalb Auxiliary; and Betty Andrews (Mrs. Russell Jr.), Past President from Rome.



Past Presidents attend a luncheon in their honor in the Hilton Arcade. (L-R): Cleo Griffin (Mrs. Louie), Claxton; Atchie Bryant (Mrs. Milton), Atlanta; Betty Andrews (Mrs. Russell Jr.), Rome; and Glenda Bates (Mrs. John), Cuthbert.



Sandee Carter (Mrs. Robert), Chairman of Convention Planning, and Millie Northup (Mrs. John), Co-chairman, handing out door prizes at the Friday luncheon.

U. S. ARMY MEDICAL DEPARTMENT

ARMY FIRST YEAR GRADUATE MEDICAL EDUCATION

GENERAL

The Army Medical Department (AMEDD) represents the largest comprehensive system of health care in the United States. Within one centrally directed system, the medical disciplines of patient care, preventive medicine, research, education, and administration are coordinated to provide a unified system of health care for approximately three and one-half million people including Active Army personnel, their dependents, as well as retired military personnel and their dependents.

During the summer of 1980, the Army is offering a large number of First Year Graduate Medical Education (FYGME) positions. Previously, most positions were filled by participants in the US Army Health Professions Scholarship Program (HPSP). However, for training beginning in July 1980, the Army will be actively seeking qualified civilian applicants who have no current Army affiliation.

DESCRIPTION

Army medical training programs are among the best in the nation. All are approved by the Liaison Committee on Graduate Medical Education of the American Medical Association. Virtually all recognized residencies are offered. Most Army training facilities are affiliated with a medical school. Medical centers and hospitals are well equipped with laboratory, medical, surgical, radiological, library and other requisite facilities. Medical records keeping is excellent.

All patients are available as teaching patients. The range of cases, both in age and complexity, is virtually impossible to duplicate. Because of the scope of the Army's activities and its highly sophisticated evacuation system, you will have the chance to see and study diseases you would never encounter in most programs. Furthermore, you have no worry about your patient's ability to pay.

The following Army FYGME programs are offered:

(1) **Flexible.** The flexible FYGME program is designed as a year of broad medical education prior to pursuing a specialized residency or as a program for individuals as yet undecided about further specialization. Four months of medicine are required in this program along with additional requirements and electives that vary slightly from teaching center to teaching center.

(2) **Categorical.** Categorical programs are offered in medicine, surgery, obstetrics/ gynecology, pathology, pediatrics, physical medicine, and family practice. The majority of the 12 month period is spent on the service concerned or in related areas and is considered by most of the appropriate specialty boards as the first year of residency training.

(3) **Categorical diversified.** These programs are essentially a combination of the above two and are offered in radiology, psychiatry, neurology, and anesthesiology. The primary emphasis is upon the major specialty with additional required and elective rotations on other services.

To find out more information concerning this program, the eligibility criteria, service obligation, benefits and application procedures contact the AMEDD Personnel Counselor serving your area.

Deadline for applications is **1 September 1979.** All applicants are encouraged to also participate in the NIRMP. Sections for the Army FYGME Program will be announced in sufficient time for selectees to withdraw from the NIRMP.

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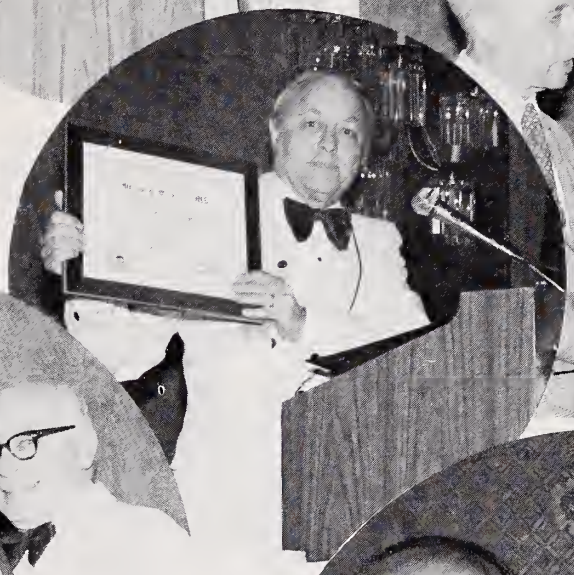
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MAG Annual Banquet



(Left): Dr. C. Emory Bohler receives "Family Physician of the Year" Award. (Below): Dr. Edgar Woody Jr. (L) is presented with a sterling silver pitcher by Dr. Carson Burgstiner for his 25-year service to MAG as Editor of the *Journal*.









(Above): Dr. Earnest C. Atkins (R) presents Civic Endeavor Award to Howard C. Derrick Jr., M.D. (Center photo): Dr. William D. Logan Jr. presents Certificates of Appreciation Awards at the Annual Banquet.

THE ANNUAL BANQUET of the Medical Association of Georgia was held in the Ballroom at the DeSoto Hilton Hotel in Savannah, Georgia, on Saturday, April 21.

The invocation was offered by Milton I. Johnson, M.D., of Macon.

Following dinner, President Carson B. Burgstiner introduced those sitting at the head table as follows: President-Elect Earnest C. Atkins and Mrs. Atkins; Immediate Past-President Milton I. Johnson and Mrs. Johnson; First Vice President L. Newton Turk III and Mrs. Turk; Chairman of the Board Joe C. Stubbs and Mrs. Stubbs; Secretary William D. Logan Jr. and Mrs. Logan; Treasurer James H. Sullivan and Mrs. Sullivan; Speaker L. C. Buchanan and Mrs. Buchanan; Vice-Speaker Jack Menendez; Guest Speaker Eloise Hope; AMA President Tom E. Nesbitt and Mrs. Nesbitt; Mrs. Burgstiner; Tennessee Medical Association President John B. Dorian and Mrs. Dorian; and South Carolina Medical Association President John C. Hawk and Mrs. Hawk.

Dr. Carson B. Burgstiner and his wife, Jacque.

Family Physician of the Year Award

Dr. Burgstiner then called on Milton I. Johnson, President of the Georgia Academy of Family Physicians, who presented the Family Physician of the Year Award to C. Emory Bohler of Brooklet.

Special Award to *Journal* Editor

In appreciation for 25 years of service as Editor of the *Journal of the Medical Association of Georgia*, Edgar Woody Jr. was presented a sterling silver engraved pitcher by President Burgstiner.

Certificates of Appreciation

William D. Logan announced that Certificates of Appreciation were being awarded to: Lee H. Battle, Rome,



President Earnest Atkins (R) presents the "Distinguished Service Award" to Charles L. Hillis of LaFayette.

as Alternate Director of Floyd-Polk-Chattooga Medical Society; Carson B. Burgstiner, Savannah, as MAG President; E. Napier Burson Jr., Atlanta, as Chairman of the Scientific Assembly Committee; Marvyn D. Cohen, Columbus, as Chairman of the Public Relations Committee; F. G. Eldridge, Valdosta, as AMA Alternate Delegate; Mr. Roy B. Evans Jr., Birmingham, Alabama, as coodinator of the MAG-SMA Scientific Assembly; J. Rhodes Haverty, Atlanta, as Chairman of the Prison Health Care Committee; William D. Logan Jr., Atlanta, as MAA Alternate Director; LaMar S. McGinnis Jr., Decatur, as Chairman of the Education Committee; Mrs. Nony McMichael, Macon, as President, MAG Auxiliary; Henry B. Scoggin, Augusta, as Richmond County Alternate Director; C. Rex Teeslink, Augusta, as MAG-SMA Scientific Assembly program coordinator; L. Newton Turk III, Atlanta, as MAG First Vice-President; and John Watson, Columbus, as President of Central Georgia HSA.

Civic Endeavor Award

Dr. Burgstiner called on President-Elect Earnest C. Atkins to announce the recipient of the 1979 MAG Civic Endeavor Award. Dr. Atkins presented the Award to Howard C. Derrick of LaFayette.

Distinguished Service Award

Earnest C. Atkins presented the Distinguished Service Award to Charles L. Hillis of LaFayette.



Dr. Carson Burgstiner (R) introduces AMA President Dr. Tom Nesbitt at the Annual Banquet.

50-Year Certificates

Dr. Burgstiner then announced that the recipients of the 50-year certificates and pins would be: Charles T. Brown, Guyton; William M. Cason, Atlanta; Hervey M. Cleckley, Augusta; J. Harris Dew, Atlanta; Alton V. Hallum, Atlanta; Guy C. Hewell, Atlanta; J. H. Jackson, Barnesville; Alton M. Johnson, Valdosta; S. B. Kitchens, LaFayette; W. M. Moncrief, Marietta; T. H. Moss, Rome; Henry R. Perkins, Augusta; Samuel F. Rosen, Savannah Beach; Russell Thomas, Americus; and W. E. Upchurch, Atlanta.

Life Members

Dr. Burgstiner then announced that the following members had been awarded Life Membership in MAG: G. Darrell Ayer Jr., Atlanta; Evert A. Bancker, Atlanta; Louis Berger, Atlanta; Stevens Byars, LaGrange; T. Sterling Claiborne, Atlanta; William R. Crowe, Atlanta; J. Harris Dew, Atlanta; Edmond W. Green, Hapeville; A. G. Hendrick, Perry; J. Lamont Henry, Atlanta; J. S. Holder, LaGrange; R. M. Joiner, Moultrie; J. R. S. Mays, Macon; Arthur J. Merrill, Atlanta; William E. Mitchell, Atlanta; E. W. Molyneaux, LaGrange; Sterling J. Ritchey, Atlanta; J. Calvin Sandison, Buford; Joseph S. Skobba, Atlanta; Morris B. Taranto, Atlanta; W. E. Upchurch, Atlanta; Exum B. Walker, Atlanta; and Hoke Wammock, LaGrange.

Dr. Burgstiner then introduced the featured speaker for the evening, Dr. Tom Nesbitt of Nashville, Tennessee, president of the American Medical Association.

Following Dr. Nesbitt's address, Dr. Burgstiner introduced Mrs. Eloise Hope of Columbus, Georgia, posing as Harriett L. Healy, Ph.D., of Washington, D.C. Mrs. Hope was the entertainment for the evening and delivered a humorous parody on health care delivery.



H. Hilt Hammett Jr., MAG's President-elect from LaGrange.



Delegates and their wives enjoy the gala MAG Annual Banquet. (L-R): Ted D. Cash and Myra Cash, Chickamauga; Glenda Simmons and Robert Simmons, Dalton; and Bob Starling, Donaldsonville.



(Above — L-R): Dr. Harrison Rogers, Mrs. and Dr. John T. Mauldin, Michael Rogers.





Above: (L-R) Dr. Julian Duttera from LaGrange, Dr. Hutson Carspecken and his wife, Peggy, Dr. Ed Woody Jr., and Dr. William H. Whaley and his wife, Jane, all from Atlanta.

(L-R) Mrs. Tilda Stubbs, Dr. James H. Sullivan, and his wife, Bunny.



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Third Session, House of Delegates
Sunday, April 22

The third session of the MAG House of Delegates meeting was called to order at 9:10 a.m. Sunday, April 22, 1979, in the ballroom of the DeSoto Hilton Hotel, Savannah, Georgia, by Speaker L. C. Buchanan.

The Reverend Thomas D. Austin, pastor of the First Baptist Church of Savannah, gave the invocation.

The Speaker then recognized Dr. John Hawk, president of the South Carolina Medical Association, and Dr. John Dorian, president of the Tennessee Medical Association, each of whom extended greetings to the MAG from their respective associations.

Speaker Buchanan asked for a report on attendance from Dr. Edwin C. Evans, reporting for the Credentials Committee, and Dr. Evans reported that 184 delegates, representing 48 component county medical societies, were registered and present and, accordingly, that a quorum did exist.

REFERENCE COMMITTEE REPORTS

Speaker Buchanan called for reports from the Reference Committee chairmen, noting that the report of Reference Committee C had not been completed at the previous meeting, and the House would, therefore, resume consideration of that committee report first. The order of Reference Committee report presentation was: Reference Committee C (continued), Reference Committee B, and Reference Committee F.



(Left photo): H. Hilt Hammett Jr., LaGrange, President-Elect of MAG; (Circle) Delegate Robert Wells, Atlanta; and Delegate Robert Simmons, Dalton, address the House on various issues.



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MAG
REFERENCE COMMITTEE
C

Charles Rey Jr., A. D. Muse, Rupert Bramblett, Chairman, continue Committee hearings.

Report of Reference Committee C

— Continued —

RUPERT H. BRAMBLETT, M.D., Chairman

COMMITTEE ON PUBLIC RELATIONS

Marvyn D. Cohen, M.D., Chairman

Your Public Relations Committee is pleased to report on its activities for 1978-79, another busy year on MAG's behalf.

Last year, the Public Relations Committee (then called Communications) was given approval by the House of Delegates to proceed with a statewide radio show called, "For Good Health." By the time this fiscal year ends, the program will have been broadcast for 72 weeks. The program is broadcast once each week over the Georgia Radio Network to over 100 stations around the state.

The Committee wishes to thank the following doctors for giving their time and talent for the broadcast: P. C. Shea Jr., Michael K. Levine, Dave M. Davis, Nanette K. Wenger, John M. McCoy, Mark E. Silverman, Thomas S. Harbin Jr., Gilbert D. Grossman, Bob G. Lanier, Albert Paul Rauber, Andrew P. Morley Jr., John N. Tripp, Ernest J. Jones, Stephen C. May Jr., David S. Sowell, John E. McCroan, David M. Taylor, John S. Turner Jr., Thomas J. Florence, William R. Elsea, John K. Davidson, Chenault W. Hailey, John E. Lee, G. Douglas Talbott, Roy A. Wiggins, John P. Wilson, Grady Clinkscales, Donald C. McLean, E. C. Evans, Frederick F. Hardin, William H. Whaley, W. Newton Long, James W. Alley, Gerald W. Vogel, William H. Stuart, William F. Wieland, Robert Lathan, W. Daniel Jordan, E. Noel Preston, Hiram M. Sturm, W. Brantley Burns Jr., David S. Brandenburg, W. Roy Mason Jr., Joseph L. Girardeau, Thomas E. Fulmer, and S. Boyd Eaton.

To our knowledge, no other state medical society has a weekly statewide radio broadcast of current health topics. The program has allowed the name of the Medical Association of Georgia to be before the public every single week.

We have also been successful in urging certain county societies to get in on the act by starting their own version of "For Good Health." This we hope to greatly expand this coming year.

Good media relations are a *must* in any good public relations program.

In Columbus, the Muscogee County Medical Society is involved in a radio show which is aired three times a day, following much the same format as "For Good Health." As for television in Columbus, on one of the local television stations 1 day each week, there is a program devoted to medical topics.

The Georgia Medical Society in Savannah has begun the task of having a physician on each week on a local television talk show.

In Macon, the Bibb County Medical Society has become interested in getting physicians and the media together.

But utilizing the media to get medicine's story across is not confined to the major market areas of Georgia. The Hall County Medical Society is one example. They are in the planning stages of their own version of "For Good Health."

MAG's Public Relations Committee urges each county medical society to contact Ken Williams, MAG's Director of Public & Professional Relations, should they wish to explore the potential of utilizing the media. MAG has on file entire scripts for sample interviews and questions, should your county society wish to start a local program such as "For Good Health."

This year has also been a busy one in the print media (newspapers, magazines, journals) as well. MAG has attempted to counter inaccurate, false, or misleading stories by the use of press releases and letters to the editor as well as personal conversations with major journalists.

MAG has sent news releases or letters to the editors

statewide on such issues as physicians' fees and the cost of living, catastrophic health insurance, the Voluntary Effort (cost containment), physicians' assistants, unnecessary surgery, who may call themselves doctors, recruiting physicians to Georgia's rural areas, what's being done for health care in the jails, etc.

MAG subscribes to a press clipping service, and every time a story appears which in any way reflects medicine in an unfair way, we have responded. The Committee wishes to thank Dr. Burgstiner for his cooperation and assistance in getting across medicine's story.

The task is not an easy one and an unending process. Each day it seems, medicine is the target for someone in the electronic or print media.

Last year the Committee urged continuance of a strong, positive on-going public relations effort. This we have done in every conceivable way by the use of the press releases, letters to the editor, the statewide broadcasts, the scheduling of physicians on TV, and our public service announcements.

Early this year we distributed our second set of public service announcements to all Georgia radio stations. Some of the television stations are still airing our "spots" from last year.

Another major project of the Committee was MAGNET '78. From the evaluations by the participants, it was a huge success. For the first time in many years, we got the Auxiliary involved in MAGNET in a specially designed program on one of the 2 days of the Conference. The program was called, "What to Do Before and After the Doctor Dies." It illustrated the need for estate planning and drew so much interest, we may repeat with a similar format.

We again co-sponsored a series of workshops throughout the state for medical assistants entitled, "Business Essentials for a Medical Office." These 1-day sessions conducted by Practice Productivity, Inc., were designed to improve the quality of care given to patients through effective practice management.

Last year your chairman proposed to the House of Delegates that we purchase video equipment to improve the effectiveness of the Committee's work. The House approved such purchase at a maximum cost of $3,000. We have explored what equipment could be purchased for that amount and have found that it is not feasible to purchase the type of equipment we need for the amount the market is now demanding. It would be far in excess of what the House budgeted and perhaps could be better spent.

The job of public relations is greatly similar to the task of the physician — keep the patient alive and well as long as possible. Our patient is MAG and our prognosis is that MAG is a healthy, viable association that is perfectly capable of projecting medicine's story for years to come, providing an active maintenance program is continued.

Public relations is not a bag of tricks. We must continue through every available means, every single day, to cultivate those who shape public opinion — the media.

It is this and more. Each of you, on a daily basis, has contact with thousands of Georgians. How your patient feels about you is probably similar to how he feels about organized medicine. We urge every physician to continue to always put his best foot forward. Every physician must have a sense of responsibility for the image medicine has in his community. Physicians must take an active role in their communities when medical care is discussed, planned, etc.

RECOMMENDATIONS

1. That the Public Relations Committee encourage each county society to initiate contact with the media in its area and to begin its own version of "For Good Health."
2. That MAGNET continue using a format relating to socioeconomic issues.
3. That the public service announcements (PSAs) be continued.
4. That the Committee conduct a workshop on public relations for county society officers and staff.
5. That the Committee engage professional public relations talents outside the Association, if and when necessary.

REFERENCE COMMITTEE DISCUSSION

Committee Report 40 asks the MAG Public Relations Committee to encourage county societies to work with the media in their area to begin their own version of "For Good Health." This report urges that the MAG-sponsored MAGNET Conference continue relating to socioeconomic issues. It also encourages this committee to continue the public service announcements (PSAs). It suggests the Public Relations Committee conduct workshops on public relations for county society officers and staff. It also recommends that the Public Relations Committee engage professional public relations talents outside the Association, if and when necessary.

Your Reference Committee listened in detail to numerous comments espoused on several public relations issues sponsored and endorsed by this Association. Your Reference Committee was extremely interested and concerned with the magnitude of the desire on the part of physicians in the state for the MAG to have good public relations.

It was brought to the attention of this Committee that a new Chairman was being appointed to the Public Relations Committee. This energetic individual is bringing specific ideas and philosophies to the committee on behalf of the membership of the Medical Association of Georgia.

Policy decisions in health care will be subject to the same political forces as all other government decisions. To be intellectually correct does not suffice. We must be able to polarize public reaction to inappropriate decisions.

Our best credential is our credibility in the public forum. Don't compromise it. The preservation of a quality health care system should become a sort of holy war, and the army of public opinion won't take kindly

to tarnished heroes. It's a good cause, let us pursue it with integrity.

Recommendation 2 of this report refers to the MAGNET Conference presenting socioeconomic issues. This Reference Committee felt adoption of this recommendation, as it is worded, would bind the MAGNET Conference to always conduct socioeconomic programs. With that in mind, your Reference Committee amends Recommendation 2 to state that the MAG continue a MAGNET Conference.

Your Reference Committee also felt that the need for public relations for MAG was paramount and therefore added an additional recommendation to this report, Recommendation 6, to read as follows:

6. That the MAG staff position of Director of Public and Professional Relations devote full-time to the areas of public relations for physicians in the MAG and the state.

RECOMMENDATIONS — Mr. Speaker, your Reference Committee advises adoption of Recommendations 1, 3, 4, and 5 and advises adoption of Recommendation 2 as amended and advises adoption by addition of Recommendation 6.

HOUSE OF DELEGATES ACTION — Voted to adopt Recommendations 1, 3, 4, and 5 of the Committee on Public Relations, voted to adopt Recommendation 2 as amended by the Reference Committee, and adopted an additional recommendation to provide that the MAG staff position of Director of Public and Professional Relations devote full time to the areas of public relations for physicians in the MAG and the state.

RESOLUTION 7
MAG PUBLIC RELATIONS PROGRAM

DeKalb Medical Society

WHEREAS, the development of a high intensity, effective Public Relations program should be a high priority for the MAG, and

WHEREAS, professional public relations consultants could assist MAG's staff in developing a highly sophisticated program to meet the needs of the organization, now, therefore, be it

RESOLVED, that the MAG Executive Committee contract with an appropriate public relations agency to accomplish the following objectives:

1. Espouse the many positive aspects of the greatest health care delivery system in the world.
2. Educate the public regarding the activities and programs of the MAG and its component medical societies.
3. Develop ideas for public service projects that would take advantage of the awesome volunteer manpower available within the organization.

REFERENCE COMMITTEE DISCUSSION

This resolution addresses itself to the MAG contract with an appropriate public relations agency to accomplish certain public relations objectives for the Association.

While the concept of using outside professional help is wholeheartedly endorsed, the subject matter of this Resolution is adequately addressed in the Recommendations of the Public Relations Committee, Committee Report 40, and when funds are needed for outside assistance, these can be obtained from the Board of Directors, therefore

RECOMMENDATION

Mr. Speaker, your Reference Committee advises Resolution 7 be not adopted.

HOUSE OF DELEGATES ACTION — Voted not to adopt Resolution 7.

RESOLUTION 13
CATASTROPHIC MEDICAL INSURANCE

Bibb County Medical Society

WHEREAS, the Catastrophic Health Insurance Bill proposes a deceptively innocuous law, and

WHEREAS, 89% of American citizens have health insurance, and

WHEREAS, 80% of these citizens have so-called major medical insurance, and

WHEREAS, this program would cost many millions of tax dollars more than its proponents will admit, and

WHEREAS, it would establish the dangerous precedent that the federal government is responsible for all citizens' health care costs, and

WHEREAS, it is sure to be perverted by manipulating the deductible levels into a *de facto* socialized medicine program, and

WHEREAS, the federal government is the cause of increased health care costs and not the solution to same, now, therefore, be it

RESOLVED, that the House of Delegates oppose this bill for the reasons stated above, and be it further

RESOLVED, that the President of the MAG transmit this Resolution to all members of the federal Congress and to the President and Chairman of the Board of the AMA.

REFERENCE COMMITTEE DISCUSSION

Resolution 13 addresses National Catastrophic Health Insurance bills currently proposed in the U.S. Congress. This Resolution espouses why the federal government should not get involved in mandating certain types of insurance coverage for the citizens of our country.

Your Reference Committee felt the language of this Resolution was not specific enough, and the authors of the Resolution agreed to the following substitute resolution:

Subject: NATIONAL CATASTROPHIC MEDICAL INSURANCE

WHEREAS, the National Catastrophic Health In-

surance bills propose a deceptively innocuous law, and

WHEREAS, approximately 89% of American citizens have health insurance, and

WHEREAS, approximately 80% of these citizens have so-called major medical insurance, and

WHEREAS, this program would cost many millions of tax dollars more than its proponents will admit, and

WHEREAS, it would establish the dangerous precedent that the federal government is responsible for all citizens' health care costs, and

WHEREAS, it is sure to be perverted by manipulating the deductible levels into a *de facto* socialized medicine program, and

WHEREAS, the federal government is the cause of increased health care costs and not the solution to same, and

WHEREAS, the MAG has supported and continues to support, on a statewide basis, voluntary catastrophic insurance as currently proposed before the Georgia House of Representatives, and

WHEREAS, catastrophic health insurance should be addressed on a state-by-state basis, therefore, be it

RESOLVED, that the House of Delegates oppose these national bills for the reasons stated above, and be it further

RESOLVED, that the President of the MAG transmit this Resolution to all members of the federal Congress and to the President and Chairman of the Board of the American Medical Association (AMA) and be it further

RESOLVED, that the MAG delegates to the AMA be instructed to carry this Resolution for introduction to the AMA House of Delegates at its next meeting.

RECOMMENDATION

Mr. Speaker, your Reference Committee advises Resolution 13 be not adopted and advises adoption of the substitute Resolution.

HOUSE OF DELEGATES ACTION — Voted to not adopt Resolution 13 and adopted in lieu thereof the Reference Committee substitute for Resolution 13 plus an additional resolve "that the MAG recognizes that there are certain gaps in the major medical insurance coverage of the American people, i.e., inability to pay the premium and inability to obtain coverage even when able to pay, and feels that the development of measures to remedy these matters at the state level are most appropriate at this time."

RESOLUTION 15
STATE OF GEORGIA DEPARTMENT OF HUMAN RESOURCES

Bibb County Medical Society

WHEREAS, the Department of Human Resources of the State of Georgia has departed from its traditional role, and

WHEREAS, it is operating five primary health care centers, and

WHEREAS, 20 more are planned in cooperation with the Appalachian Regional Commission and the federal Department of Health, Education, and Welfare using money collected in taxes from Georgia citizens, and

WHEREAS, Dr. Benjamin B. Okel, Chairman of the Physical Health Committee of the Board of Directors of the Department of Human Resources, has stated at their board meeting on July 19, 1978, that acquisition of funds to develop primary health care centers throughout the state is the number two priority of his committee, and

WHEREAS, equivalent quality medical care to that provided by physicians cannot be rendered by extended-practice nurses under ostensible physician supervision, and

WHEREAS, the cost-per-patient encounter is likely to exceed that of care in a physician's private office, and

WHEREAS, this will set up and subject a portion of citizens to second class medical care, and

WHEREAS, it is incongruous for the state to operate a State Medical Education Board to grant loans to students who pledge to practice in cities of less than 15,000 population and a Joint Family Practice Board to establish, supervise and partially fund post graduate family practice training and then to set up these clinics in the very areas that would be largely served by the beneficiaries of these loans and grants, and

WHEREAS, the solution to this problem lies in having the state and federal governments pay standard medical fees to physicians for services it wishes to purchase, as it does services and goods it purchases in other fields, now, therefore, be it,

RESOLVED, that the MAG House of Delegates deplores and opposes these actions against our citizens by the state and federal governments, and be it further

RESOLVED, that the MAG Board of Directors and Executive Committee be directed to deal with this problem legislatively as is demanded by this situation.

REFERENCE COMMITTEE DISCUSSION

Resolution 15 addresses the role of the Department of Human Resources of the State of Georgia in primary health care centers throughout the state and questions the quality of medical care rendered in these health clinics. This Resolution also acknowledges the possibility that the cost of medical care on a patient-by-patient basis rendered in these clinics exceeds that of the care in a physician's office.

Your Reference Committee heard numerous testimonies on the activities of the Board of Human Resources in setting up and initiating primary health care centers in the state with little, or no, physician involvement or the need for said clinics due to the shortage of physicians in that area.

RECOMMENDATION

Mr. Speaker, your Reference Committee advises adoption of Resolution 15.

HOUSE OF DELEGATES ACTION — Adopted Resolution 15.

RESOLUTION 18
HOSPITAL SATELLITE CLINICS

William C. Collins, M.D.

WHEREAS, contact through a physician's office has been the usual method of access into the health care system, and

WHEREAS, it is appropriate for hospitals to maintain emergency and outpatient clinic facilities for the benefit of its community constituency and medical staff, and

WHEREAS, the establishment of hospital satellite clinics or "branch offices" is in opposition to the accepted pattern of medical care and would be a duplication of physicians' offices, and

WHEREAS, it is known that medical care is more costly in hospital outpatient departments and satellite clinics than in physicians' offices, now, therefore, be it

RESOLVED, that the House of Delegates of MAG disapproves the establishment of hospital clinics, facilities, satellites, and "branch office emergency rooms" at locations remote from the immediate hospital complex site.

REFERENCE COMMITTEE DISCUSSION

Resolution 18 addresses the growing activity in this state debating and considering "branch offices" or "branch emergency clinics" in locations outside the direct vicinity of the existing hospital.

Numerous individuals testified as to their concern regarding satellite clinics operated by hospitals and that this problem primarily addressed the physicians in the locations, towns, and communities in which these hospitals were debating such satellite clinics.

Your Reference Committee amends the RESOLVED of this Resolution to read as follows:

RESOLVED, that the House of Delegates of MAG disapproves of the concept of satellite hospital clinics, facilities, and "branch office emergency rooms" at locations remote from the immediate hospital complex site.

RECOMMENDATION

Mr. Speaker, your Reference Committee advises adoption of Resolution 18 as amended.

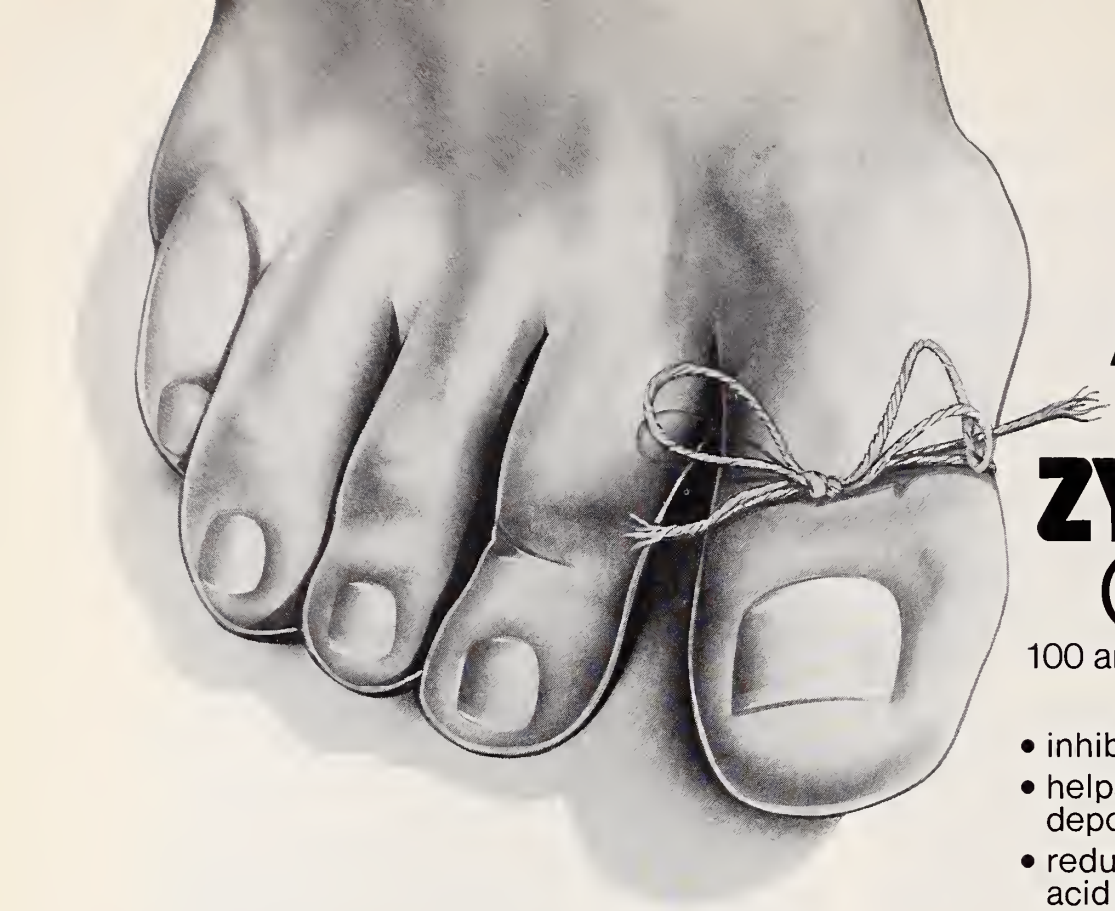
HOUSE OF DELEGATES ACTION — Adopted Resolution 18 as amended by the Reference Committee.

Mr. Speaker, this concludes the report of Reference Committee C. Mr. Speaker, your Reference Committee would like to express its appreciation to all who participated in our discussions and deliberations.

ANNOUNCEMENT: Delegate Robert Logan, Savannah, extended a standing invitation for the MAG House of Delegates to meet every second year in Savannah.



St. John's Catholic Cathedral, Savannah.



A reminder

ZYLOPRIM®
(allopurinol)

100 and 300 mg scored Tablets

- inhibits uric acid formation
- helps prevent urate crystal depositions in synovia
- reduces risk of uric acid lithiasis

INDICATIONS AND USE: This is not an innocuous drug and strict attention should be given to the indications for its use. Pending further investigation, its use in other hyperuricemic states is not indicated at this time.

Zyloprim® (allopurinol) is intended for:

1. treatment of gout, either primary, or secondary to the hyperuricemia associated with blood dyscrasias and their therapy;
2. treatment of primary or secondary uric acid nephropathy, with or without accompanying symptoms of gout;
3. treatment of patients with recurrent uric acid stone formation;
4. prophylactic treatment to prevent tissue urate deposition, renal calculi, or uric acid nephropathy in patients with leukemias, lymphomas and malignancies who are receiving cancer chemotherapy with its resultant elevating effect on serum uric acid levels.

CONTRAINDICATIONS: Use in children with the exception of those with hyperuricemia secondary to malignancy. The drug should not be employed in nursing mothers.

Patients who have developed a severe reaction to Zyloprim should not be restarted on the drug.

WARNINGS: ZYLOPRIM SHOULD BE DISCONTINUED AT THE FIRST APPEARANCE OF SKIN RASH OR ANY SIGN OF ADVERSE REACTION. In some instances a skin rash may be followed by more severe hypersensitivity reactions such as exfoliative, urticarial and purpuric lesions as well as Stevens-Johnson syndrome (erythema multiforme) and very rarely a generalized vasculitis which may lead to irreversible hepatotoxicity and death.

A few cases of reversible clinical hepatotoxicity have been noted and in some patients asymptomatic rises in serum alkaline phosphatase or serum transaminase have been observed. Accordingly, periodic liver function tests should be performed during the early stages of therapy, particularly in patients with pre-existing liver disease.

Patients should be alerted to the need for due precautions when engaging in activities where alertness is mandatory.

Nevertheless, iron salts should not be given simultaneously with Zyloprim. This drug should not be administered to immediate relatives of patients with idiopathic hemochromatosis.

In patients receiving Purinethol® (mercaptopurine) or Imuran® (azathioprine), the concomitant administration of 300-600 mg of Zyloprim per day will require a reduction in dose to approximately one-third to one-fourth of the usual dose of mercaptopurine or azathioprine. Subsequent adjustment of doses of Purinethol or Imuran should be made on the basis of therapeutic response and any toxic effects.

Usage in Pregnancy and Women of Childbearing Age: Zyloprim® (allopurinol) should be used in pregnant women or women of childbearing age only if the potential benefits to the patient are weighed against the possible risk to the fetus.

PRECAUTIONS: Some investigators have reported an increase in acute attacks of gout during the early stages of allopurinol administration, even when normal or subnormal serum uric acid levels have been attained.

It has been reported that allopurinol prolongs the half-life of the anticoagulant, dicumarol. This interaction should be kept in mind when allopurinol is given to patients already on anticoagulant therapy, and the coagulation time should be reassessed.

A fluid intake sufficient to yield a daily urinary output of at least 2 liters and the maintenance of a neutral or, preferably, slightly alkaline urine are desirable to (1) avoid the theoretic possibility of formation of xanthine calculi under the influence of Zyloprim therapy and (2) help prevent renal precipitation of urates in patients receiving concomitant uricosuric agents.

Patients with impaired renal function require less drug and should be carefully observed during the early stages of Zyloprim administration and the drug withdrawn if increased abnormalities in renal function appear.

In patients with severely impaired renal function, or decreased urate clearance, the half-life of oxipurinol in the plasma is greatly prolonged. Therefore, a dose of 100 mg per day or 300 mg twice a week, or perhaps less, may be sufficient to maintain adequate xanthine oxidase inhibition to reduce serum urate levels. Such patients should be treated with the lowest effective dose, in order to minimize side effects.

Mild reticulocytosis has appeared in some patients.

As with all new agents, periodic determination of liver and kidney function and complete blood counts should be performed especially during the first few months of therapy.

ADVERSE REACTIONS:

Dermatologic: Because in some instances skin rash has been followed by severe hypersensitivity reactions, it is recommended that therapy be discontinued at the first sign of rash or other adverse reaction (see WARNINGS). Skin rash, usually maculopapular, is the adverse reaction most commonly reported.
Exfoliative, urticarial and purpuric lesions, Stevens-Johnson syndrome (erythema multiforme) and toxic epidermal necrolysis have also been reported.
A few cases of alopecia with and without accompanying dermatitis have been reported.
In some patients with a rash, restarting Zyloprim (allopurinol) therapy at lower doses has been accomplished without untoward incident.

Gastrointestinal: Nausea, vomiting, diarrhea, and intermittent abdominal pain have been reported.

Vascular: There have been rare instances of a generalized hypersensitivity vasculitis or necrotizing angiitis which have led to irreversible hepatotoxicity and death.

Hematopoietic: Agranulocytosis, anemia, aplastic anemia, bone marrow depression, leukopenia, pancytopenia and thrombocytopenia have been reported in patients, most of whom received concomitant drugs with potential for causing these reactions. Zyloprim® (allopurinol) has been neither implicated nor excluded as a cause of these reactions.

Neurologic: There have been a few reports of peripheral neuritis occurring while patients were taking Zyloprim. Drowsiness has also been reported in a few patients.

Ophthalmic: There have been a few reports of cataracts found in patients receiving Zyloprim. It is not known if the cataracts predated the Zyloprim therapy. "Toxic" cataracts were reported in one patient who also received an anti-inflammatory agent; again, the time of onset is unknown. In a group of patients followed by Gutman and Yü for up to five years on Zyloprim therapy, no evidence of ophthalmologic effect attributable to Zyloprim was reported.

Drug Idiosyncrasy: Symptoms suggestive of drug idiosyncrasy have been reported in a few patients. This was characterized by fever, chills, leukopenia or leukocytosis, eosinophilia, arthralgias, skin rash, pruritus, nausea and vomiting.

OVERDOSAGE: Massive overdosing, or acute poisoning, by Zyloprim has not been reported.

HOW SUPPLIED: 100 mg (white) scored tablets, bottles of 100 and 1000; 300 mg (peach) scored tablets, bottles of 30, 100 and 500. Unit dose packs for each strength also available.

Complete information available from your local B. W. Co. Representative or from Professional Services Department PML.

U.S. Patent No. 3,624,205 (Use Patent)

Wellcome

Burroughs Wellcome Co.
Research Triangle Park
North Carolina 27709



Dr. William C. Waters III, Chairman, gives Reference Committee B's report to the House.

Report of Reference Committee B

WILLIAM C. WATERS III, M.D., Chairman

Chairman Waters reported that Reference Committee B met in the North Ballroom at the DeSoto Hilton in Savannah on Friday, April 20, 1979, and thoroughly examined and carefully considered all items referred to that Committee. Members of the Reference Committee present included William C. Waters III, M.D., Atlanta, Chairman; Donald Manning, M.D., Brunswick; Bradwell R. McAlister Jr., M.D., Gainesville; J. Moultrie Lee, M.D., Savannah; Philip Z. Israel, M.D., Smyrna; O. Wytch Stubbs Jr., M.D., Tucker.

COMMITTEE ON NURSING

J. Rhodes Haverty, M.D., Chairman

The Committee on Nursing continued to be active, meeting five times during the past year. Three of the meetings were of the Statewide Joint Practice Committee for Medicine and Nursing, composed of an equal number of committee members and nurses representing the Georgia Nurses Association (GNA).

The extended role of the nurse, as in past years, was the focus of most of the committee's discussions. The committee sought clarification of the working relationship that ought to exist between the physician and the extended-role nurse and recommended that a statement be drawn up and agreed upon by both professions. As a result, the Joint Practice Committee adopted the following statement for approval by the MAG and GNA boards of directors:

STATEMENT ON NURSE PRACTITIONERS

The MAG (or GNA) recognizes that nurse practitioners are health professionals independently licensed to provide nursing care, and that such practice need not be under physician supervision.

The association also recognizes that certain acts performed by nurse practitioners are properly considered to be medical acts and, as such, should be performed under the supervision of a licensed physician. Medical acts should not be performed by nurse practitioners where medical protocols solely substitute for supervision by a physician.

Physician supervision of a nurse practitioner means that the physician is responsible for medical acts performed by the nurse practitioner. The supervising physician or his physician designee must be available for daily consultation with the nurse practitioner and must regularly and systematically review the medical care (as reflected in charts and notes) of patients seen by the nurse practitioner.

In December 1978, the MAG Board of Directors adopted the statement as MAG policy, with one change: The word "practitioner" was stricken wherever it occurred. Thus, MAG's policy statement is called "Statement on Practice of Nursing." Subsequently, the Joint Practice Committee met, disapproved the MAG Board's change, and unanimously approved the original form of the statement. The GNA board also approved the original version of the statement.

The committee was given an additional charge by the MAG:

1. Report the number of nurse practitioners in practice and the activities of the GNA in pushing the concept and utilization of nurse practitioners.
2. Monitor the state's program to set up fee-for-service medical practices utilizing nurse practitioners in public health offices.

3. Give an opinion on:
 (a) whether more nurse practitioners are needed in view of the approaching surplus of physicians;
 (b) what will happen when a confrontation between physicians and nurse practitioners occurs in the next few years?
 (c) whether it is in the public interest to encourage the development of a two-level system of medical care;
 (d) the ultimate effect of the above type of medical care on the primary care physicians;
 (e) how government misuse of nurse practitioners, through utilization in lieu of physicians in armed service and VA hospitals, affects their acceptance in the private sector.
4. Report at regular intervals to the Executive Committee so it will be kept informed on this serious matter.

In preparing to meet the above charge, MAG staff for the committee corresponded with a number of government agencies and professional organizations on the federal and state levels and prepared a summary report on their policies on nurse practitioners. This report was helpful in formulating the following answers to the charge:

1. The number of nurse practitioners practicing in Georgia is not officially known, but the GNA has estimated that there are 150-200 practicing in various settings and roles, such as joint practice with medical groups, joint practices with solo physicians, independent nursing practice, and primary care practice with medical protocol. The GNA endorses the 1975 report of the Statewide Master Planning Committee for Nursing Education, which recommends a health care system utilizing nurse practitioners more widely than at present.
2. To the Committee's knowledge, the state does not intend to set up fee-for-service medical practice utilizing nurse practitioners in public health offices. MAG's Committee on Medical Practice is monitoring the Department of Human Resources' plans for establishing rural health clinics, and the reader is referred to that committee's report.
3. The Committee offers the following opinions:
 (a) Nurse practitioners have been shown to increase the quantity and quality of care under the appropriate supervision of physicians, regardless of the number of physicians in an area.
 (b) The Committee sees no necessity for a confrontation between physicians and nurse practitioners. Teams of physicians and nurse practitioners practicing together should be the rule, not the exception.
 (c) The Committee would not encourage the development of a two-level system of medical care; with the proper supervision of nurse practitioners, the level of care is enhanced.
 (d) The care delivered by primary care physicians can be increased in quality and quantity by the utilization of appropriately supervised nurse practitioners.
 (e) The utilization of nurse practitioners in government hospitals is not under control of the state governments. There are adequate state controls for civilian use of health care personnel. The misuse of nurse practitioners by the federal government does not affect the private sector.
4. The chairman of the Committee has reported from time to time to the MAG Executive Committee and Board of Directors on issues related to nursing practice.

During the past year the Composite State Board of Medical Examiners requested the legal opinion of the state attorney general as to whether "protocol" medicine administered by a nurse constitutes the unauthorized practice of medicine. On Jan. 15, 1979, the attorney general rendered his opinion that the practice of "protocol" medicine by a licensed nurse when prescribed by a physician would not be the unauthorized practice of medicine by the nurse; the question of whether the prescribing physician was practicing in accordance with the Medical Practice Act would be a factual question to be resolved by the Composite State Board on a case-by-case basis. The attorney general also stated in his opinion that "it seems clear that it is not necessary that the physician be in the immediate presence of the patient and the nurse when medication is administered or when the medical treatments prescribed by the physician are given. On the other hand, it is equally clear that there are certain things which the physician could not authorize the nurse to do even in his presence, such as the writing of prescriptions for medications."

The Committee will continue to monitor the situation with regard to the practice of extended-role nurses.

REFERENCE COMMITTEE DISCUSSION

The bulk of this extensive report focused on the question of the extended role of the nurse in modern medicine. A distinction was made between nursing care and medical acts, and it was pointed out that all medical acts must be under the direct supervision of the physician. It was pointed out that the statement of the Joint Practice Committee had been adopted by the MAG Board after modification of the report to eliminate the term "nurse practitioner" and substitute simply "nurse" or "nursing."

Extensive testimony was delivered to your Reference Committee by MAG members and others regarding such topics as protocol medicine, professional vs. technical nursing, two-level care, and the like. Multiple anecdotal reports were made relative to instances of apparent inappropriately dispensed or prescribed medications within industrial, institutional, and clinic settings. The Committee learned that there are currently 31 primary care centers established in Georgia. These centers are funded by various mechanisms and are primarily staffed with nurses practicing in an extended role.

No specific recommendations for action were offered by the Report of the Committee on Nursing;

rather five opinions were offered, as outlined in the report. In general, these opinions suggested that nurse practitioners have been shown to increase the quantity and quality of care, that no necessity for physician-nurse practitioner confrontation existed, and that no likelihood for development of a two-level system of medical care seems in the offing.

After studying the testimony, and after considerable deliberation, your Reference Committee felt that the concept of the nurse in the extended role of nurse practitioner or physician extender evolved during the period when a shortage of physicians was claimed to have existed. With the advent of doubling of medical school output, increased stress on production of primary care physicians, and in some cases shortening of physician training periods, a surplus, rather than a shortage of physicians in this country is predicted by 1980. On the other hand, a widely appreciated shortage of nurses functioning in the traditional role has developed. Thus, while the depth and breadth of nurse training should be encouraged, and while the enhanced quality of nursing performance is much to be desired, the extended role of the nurse as a primary provider of medical care does not appear to be needed at the present time.

Therefore, your Reference Committee could not concur with the opinions expressed in the Nursing Committee report, and your Reference Committee would instead make the following recommendations for adoption.

RECOMMENDATIONS

1. The existing MAG policy that nurses should continue to function under the direction and direct supervision of physicians and not as independent agents should be reiterated and emphasized.

2. That, as one means of emphasizing the supervisory role of the physician, fiscal charges allocated to medical acts (as distinguished from nursing acts) performed by nurses on the prescription of a physician be made by the supervising physician rather than by the nurse.

3. That the MAG adopt as policy the statement, "The Medical Association of Georgia deplores inappropriate use of nursing personnel outside the direct supervision of the physician in government settings, in which the nurses are reported to be functioning as independent medical practitioners."

4. The MAG Committee on Nursing is urged to continue with its intended function of monitoring progress of the concept of the nurse in the extended role and also enhance the concept and encourage the quality of nursing training in the traditional role.

HOUSE OF DELEGATES ACTION — The House adopted each of the four Recommendations as stated by the Reference Committee.

COMMITTEE ON PHYSICIAN'S ASSISTANTS

William J. Rawls, M.D., Chairman

The Committee has continued to be active, with three meetings held during the year. In addition, a number of committee members attended a 2-day September conference for physicians on the role of the Physician's Assistant (PA) in Georgia. The conference was organized by Neil Shulman, M.D., consultant for primary health care to the Georgia Department of Human Resources, and some 50 physicians attended.

This year the Committee was given a special charge by the MAG:

1. Monitor the number of PAs in training at Emory University and the Medical College of Georgia, the cost of training a PA as compared to the cost of training a physician, the yearly federal funding for PA training programs in Georgia, the number of PAs certified in Georgia, and the number currently employed.
2. Monitor the state's program to set up fee-for-service medical practice utilizing PAs in public health offices.
3. Give an opinion on:
 A. Whether more PAs are needed, in view of the approaching surplus of physicians,
 B. What will happen when a confrontation between physicians and PAs occurs in the next few years,
 C. Whether it is in the public interest to encourage the development of a two-level system of medical care,
 D. The ultimate effect of the above type of medical care on primary care physicians,
 E. How government misuse of PAs, through utilization in lieu of physicians in armed service and VA hospitals, affects their acceptance in the private sector.
4. Study Georgia House Bill 1636 (1978 session) as a possible prototype of more onerous future legislation, and recommend legislation which MAG should consider to counteract such legislation.
5. Document abuses and report at regular intervals to the MAG Executive Committee so it will be kept informed on this serious matter.

Following is the Committee's report on the above charge:

1. There are 78 PAs in training at Emory University and 46 at the Medical College of Georgia, for a total of 124. The cost of training a PA at Emory is about $7,500 a year; and the cost at MCG is about $5,500 a year. It is estimated that it costs between $15,000 and $25,000 a year to train a physician. The 1978 federal funding for the Emory PA program was $200,000; and the 1978 funding for the MCG program was $210,000. As of November 1978, there was 125 PAs with temporary ("grandfather clause") certification and 202



Delegates listen to legislation discussion in Reference Committee B meeting.

with permanent certification, for a total of 327 certified PAs. A high percentage of the total is currently employed in Georgia, although the exact number is hard to determine because the Composite State Board of Medical Examiners is not always informed promptly when a PA terminates his work with a particular physician. Neither PA training program has any difficulty placing its graduates, according to the directors of the programs.

2. As far as the Committee can ascertain, the state is not planning now or in the future to set up fee-for-service medical practice utilizing PAs in public health offices.
3. The Committee offers the following opinions:
 A. The need for PAs cannot be determined. However, the important issue is not the relative total number of PAs and physicians but the distribution (or maldistribution) of medical care personnel. According to state law, every PA must be employed by a physician and must work under the direct supervision of that physician. Therefore, one should not treat the question of need for PAs apart from the question of need for physicians.
 B. There will be no confrontation between physicians and PAs with the state law for PAs structured as it is now.
 C. Assuming that PAs as regulated by law are the supervised extension of physicians, the utilization of PAs should not lead to a two-level system of medical care.
 D. The ultimate effect of utilizing PAs, within the present structure of the law, should be the extension of quality care rendered by primary care physicians.
 E. The Committee is aware that the armed services do not have to follow state laws governing PAs. The Committee feels the MAG has no control over this situation and further believes that government utilization of PAs does not affect the private sector.
4. The Committee studied the history of House Bill 1636 and agreed that it is concerned with any bill that would alter the present legal structure of PAs.
5. No abuses concerning PAs have been reported to the Committee during the past year, but the Committee will be receptive to such reports in the future.

In its 1978 annual report, the Committee expressed concern that it lacked sufficient guidance from the present Georgia law governing PAs on the matter of the appropriate supervision of these new health professionals.

The Committee sensed that a number of physicians in the state shared its concern, and it therefore devoted a good deal of study to the issue. The attached document, "Proposed Rules and Regulations Regarding Performance of Medical Acts of Physician's Assistants," is the result of that study.

RECOMMENDATIONS

1. That the MAG adopt as policy the document "Proposed Rules and Regulations Regarding Performance of Medical Acts by Physician's Assistants," and
2. That MAG recommend to the Composite State Board of Medical Examiners that these "Proposed Rules and Regulations" be added to the present rules and regulations governing PAs.

PROPOSED RULES AND REGULATIONS REGARDING PERFORMANCE OF MEDICAL ACTS BY PHYSICIAN'S ASSISTANTS

The physician's assistant who performs medical acts is an agent of a specific licensed physician. The PA is not independently licensed to perform medical acts but is only authorized to perform such services under the license of the responsible physician.

Applications for State Board approval of a PA under Code Chapter 84-6204 is considered a joint act of the PA and the responsible physician. This implies that each party agrees to the terms and provisions specified in the application.

Reference Committee B



Committee B members, Drs. William C. Waters III, Chairman, Donald Manning, Bradwell McAlister, O. Wytch Stubbs.

It is recognized that there are an infinite variety of acts, tasks, and functions which might be delegated to a PA, and an infinite variety of settings and circumstances under which these services might be performed. The paragraphs which follow represent an attempt to make explicit an understanding of the obligations of the licensed physician and the PA in several of the more common settings. These understandings are considered as having been accepted by the applicants unless otherwise described in the application for approval.

SETTING

A. Physician's office

In such settings it is agreed:

1. That the physician is normally available for immediate on-site consultation with the PA about any matter in question — a point in the patient's history, an abnormal physical finding, etc.
2. That the physician regularly and systematically checks the charts and notes of patients seen by the PA, checking for accuracy and completeness of such records, and, in particular, the suitability of the plan of management.
3. That the physician approves and signs all prescriptions for drugs.
4. That if the physician is not available for immediate on-site consultation with the PA, he should be readily accessible. The most logical yardstick for measuring physician accessibility probably lies in specification of the maximum time required for summoning and responding by the supervising physician for on-site consultation. However, even this must be viewed in context. A time delay of 15 to 30 minutes might be permissable in certain settings and not in others. In any case, the maximum allowable time delay should be specified in the individual application for State Board approval of the PA.
5. That if the physician is temporarily inaccessible, another licensed physician approved as a secondary supervisor will be designated as "on call" for such consultation. This physician must abide by the same standards of accessibility as apply to the primary supervising physician. When no supervising physician is available, the PA should not be providing routine medical care. However, in an emergency situation the PA may institute life-supportive measures until a physician can be located.
6. That the supervising and responsible physician is competent to perform, and to properly supervise all medical acts or tasks performed by the PA, and is registered with the Composite State Board of Medical Examiners as the supervising physician for that PA.
7. That all patients are informed of the background and/or professional identity of the PA, and that an identifying tag is worn with the name and the words "physician's assistant" (not PA) thereon clearly visible from a normal conversational distance.

B. Hospital

Under the limitations of their job descriptions, PAs can work in the hospital setting, but it is pointed out that there are special problems, including those arising out of interrelationships with other licensed and unlicensed personnel employed within this setting.

The PAs' functions in this setting are also regulated by the medical staff bylaws and regulations. Many hospitals establish a special associate medical staff membership category and require that all PAs performing medical acts within the hospital must apply for and be accepted to such membership prior to any activity within the hospital. This is a highly recommended procedure.

The usual process is that the application for such membership is jointly filed by the PA and the supervising

physician, reviewed for personal and professional qualifications by the credentials committee, and presented for approval by the medical staff. Hospital personnel, including administration and nursing, should be promptly informed of the medical staff's approval of the PA. This process serves two purposes: assuring the medical staff that the PA meets professional and ethical standards, and publicizing the presence of the PA to the medical staff, nursing staff, and the hospital administration.

Although any new patient contact must be initiated by the supervising physician, initial workup of patients is often delegated to the PA. This is an appropriate function if checked and countersigned by the physician on his/her next visit to the hospital or within 24 hours. These workups should meet the standards set for workups performed by the physician staff of the hospital. It is agreed that any abnormalities or other findings are noted by the physician, and that his countersignature indicates his agreement with the findings recorded.

Writing of initial orders may be delegated to a PA. These activities are very important in that they impinge on the function of others, such as the registered and licensed practical nurses assigned to the ward. Regulations require that written instructions or guidelines must be on file and available to the nurse accepting such orders, as a means of assurance that these orders are emanating from the supervising physician and that they are within the authority which this physician has delegated to the PA. All orders should be checked and countersigned by the physician at his/her next visit, or within 24 hours, whether or not these are covered by written instructions or guidelines.

The initial orders which a PA might be authorized to write on a patient are of several types:

a. Status orders — indicating the condition of the patient and usually used by the hospital staff to regulate visitors, to transmit to callers, etc. (e.g. "condition fair").
b. Activity orders — indicating the degree of restriction of position or activity of the patient (e.g. "bed rest").
c. Diet and oral fluid orders — indicating the amount and type of food and/or oral fluids (e.g. "low salt diet," "force fluids," etc.).
d. Test and Procedure orders — indicating those tests and procedures necessary for care of the patient (e.g. "urinalysis in a.m.," "schedule for I.V. urogram," etc.).
e. Ward observation and measurement orders — indicating those procedures to be carried out by hospital staff personnel (e.g. "BP twice daily in supine position," "record fluid intake and output," etc.).
f. Continuation orders for medication — indicating those drugs which are to be given to the patient as continuation of medication previously prescribed by a licensed physician for that patient and which the patient is taking at the time he/she is admitted to the hospital. Any new medication must be ordered by the physician.

A glance at the above list reveals the enormous range of orders which may be necessary for diagnosis and treatment of the patient in the hospital setting. Some are routine and could be delegated with very little supervision. Others might need very close supervision.

A supervising physician might consider standing orders of a blanket type covering those types of orders which would require less supervision. These might include orders of types a, b, c, and d as described above. Orders of type e (ward observation and measurement orders) might require more specification, but still be of the blanket type.

Such written orders might take the following form: "John A. Doe, Physician's Assistant, is hereby authorized to write the following type orders on patients admitted under my responsibility:

a. Status orders
b. Activity orders
c. Diet and fluid orders
d. Test and procedure orders for the following tests/procedures: Routine blood and urine tests; stool cultures and tests; cultures on blood, urine and body fluids; radiologic examinations including contrast studies; radioisotopic studies, and electrocardiograms. This shall not include authorization to order computerized tomography studies, bronchoscopy, or fiberscopic examinations.
e. Ward observation and measurement orders, with the stipulation that if these are to be carried out for over 24 hours, these must be countersigned by me.

Signed _____, M.D."

The above written orders should cover the majority of those orders of a routine or housekeeping variety, which are necessary for efficient operation of a unit and for patient comfort, yet carry little risk in case of error.

There are also orders which must be written in an emergency, to cover those rare but urgent situations which may arise in any hospital environment. These can never be adequately covered in a set of written orders, and the only advice which can be given is that the patients' interests must take precedence, and the PA involved must work out each solution ad hoc.

The same standards of accessibility of the supervising physician should apply in the hospital setting as in the office setting.

The PA, working in the hospital setting, might be delegated any of a wide variety of medical procedures to be performed on patients under the care of the supervising physician.

It is agreed that the PA must have received adequate and proper instruction in the performance of each such procedure, and that the supervising physician has personally observed the PA performing such procedures. The delegation of these tasks infers that the physician is satisfied that the PA has the requisite skill, and that the physician agrees with the technique and the safeguards under which the procedure is done.

It is also agreed that the physician will not delegate tasks in which he/she is not capable of judging the quality of the skill and technique employed.

Some hospitals may allow the physician to delegate to the PA the task of writing discharge summaries on patients under the care of the supervising physician. All such

summaries should be carefully read and countersigned by the physician. The physician is reminded that this function is not only an excellent opportunity to review the case but can also serve as an important review of the PA's role in the hospital setting. Delegation of this task should be done with great care and forethought.

C. Emergency Room

The PA may utilize the emergency room in the course of assisting the physician from a predominantly office setting. For example, a patient may call when the office is closed, and for convenience the emergency room may be the place of meeting. Such occasional or incidental use is not considered as different from previously discussed settings. It is required that such activities be closely supervised by the supervising physician, as is described under the office setting, and that these activities conform to hospital staff bylaws. The same standards of accessibility of the supervising physician apply here.

If the supervising physician's primary location of medical practice is in an emergency room, then it would be appropriate for him to utilize a PA to work in the emergency room as a primary responsibility. In this setting, the PA's activities must be limited to those times when his designated supervising physician is physically present in the emergency room or readily available. As with the office setting, accessibility is measured by specification of the maximum time required for summoning and responding by the supervising physician for on-site consultation.

There are special problems in working as a PA in this site. The first is the fact that emergencies of a wide variety may enter at any time, including multiple-person disasters. Second, the patients are usually transient, with no previous relationship with the physician. They usually come because of an unscheduled, unexpected illness or accident, and are more prone to be upset and/or hostile. These factors make the emergency room a frequent source of misunderstanding and litigation.

The PA in the emergency room setting must be clearly identified, both by proper name tags as previously described and by verbal introductions. The functions to be carried out must be performed to the same standards as would be expected of a physician.

D. Nursing Home or Extended Care Facility

The nursing home or similar long-stay facility shares some of the problems of the hospital, but has the advantage that there is less turnover of patients, and the problems are usually of a less acute nature.

Such facilities are a suitable site for the utilization of PAs, under the same standards as apply to the utilization of the PA in the hospital setting.

As in the hospital setting, the initial workup of newly admitted patients is often delegated to PAs after the physician has initiated the patient contact. If this is the case, these workups should meet the standards set for workups performed by physicians. It is agreed that all abnormalities are noted by the supervising physician. The workup should be countersigned by the physician at his/her next visit, or within 72 hours, whichever is sooner, and this countersignature indicates agreement with the findings as recorded by the PA.

The writing of orders is subject to the same rules and restrictions as were described in Section B above. The reader is referred to this section for details.

The PA may perform a wide variety of medical procedures in the setting of a nursing home. It is expected that he/she has received proper instruction in the performance of such procedures, and that the supervising physician has observed the PA performing such procedures, and agrees with the technique and the safeguards under which the procedure is done.

The standards of accessibility of the supervising physician should be the same in the nursing home setting as in the office and hospital settings.

The supervising and responsible physician must be competent to perform and to properly supervise all medical acts or tasks performed by the PA in the nursing home, and must be registered with the Composite State Board of Medical Examiners as the supervising physician for that PA.

UNDERSTANDING

The physician and the PA should be in general agreement with the principles contained in this document; or, if not, these differences should be spelled out in detail in the PA's job description, which describes the individual practice setting proposed. This job description should also contain specific data which will enable an evaluation of the degree to which the practice conforms to these expectations.

REFERENCE COMMITTEE DISCUSSION

Your Reference Committee B reviewed in detail the report of the Committee on Physician's Assistants and was impressed with the diligence and effort represented in the extensive report submitted by that body. The Committee report included explicit proposed rules and regulations regarding performance of medical acts by PAs, recapitulating the fact that the PA performing medical acts is an agent of a specific licensed physician. In addition, the Committee provided extensive guidelines for the contract between a physician and a PA, specifying details of duties to be performed and at what times and under what conditions.

Considerable testimony was offered to the Committee by a variety of members, indicating dissatisfaction with the PA program as a whole, citing specific experiences. Some physicians, previously enthusiastic about the PA concept, have become disillusioned with its value and concerned about the ability of the physician to supervise PA activities.

Your Reference Committee felt that a number of the recommendations included in this Committee do have merit. It was felt they could be particularly useful in providing guidance to physicians and their PAs in developing specific job descriptions as well as providing a structure for discussions with the State Board of Medical Examiners. However, some aspects of these

recommendations, if adopted generally, could create serious problems. One example is the recommendation which allows PAs to perform histories and physicals. It was the consensus of the testimony received by your Reference Committee that physicians should retain this vital function.

Other areas of grave concern related to the possibilities that patients would not be seen by a physician at all in his/her office and that admission orders could be in effect for 24 hours without physician approval.

It is the opinion of your Reference Committee that the previously expressed policy of the MAG more accurately reflects the position of the society than the proposals of the Committee on Physician's Assistants, and that the previously adopted policy should not be supplanted.

RECOMMENDATIONS

Mr. Speaker, your Reference Committee proposes that Recommendations 1 and 2 of the Committee report be not adopted. Instead, it recommends reiteration of previous MAG policy as follows:

1. That MAG recommend to those currently involved in training and certifying PAs in Georgia, that until the need for more PAs is documented, the training and certification of PAs in Georgia be terminated as the current training cycles end.

2. That MAG continue to promulgate the following definition of direct personal supervision: "Direct personal supervision is defined as being in the physical presence of the responsible physician or his covering physician designee on a daily basis and that all decisions regarding diagnosis and treatment must be at the direct physical or phone contact with said responsible physician or his covering physician designee," and that MAG recommend the adoption of this definition by the Georgia Composite State Board of Medical Examiners.

3. That the Executive Committee be requested to appoint a special delegation to urge the discontinuation of the PA program to the appropriate officials involved in training and certifying these individuals.

4. That we request the Committee on Physician's Assistants to continue its efforts in developing guidelines which may, with the approval of the Executive Committee, assist the Composite Board in its task of developing and improving rules and regulations for PAs.

5. That MAG actively oppose any proposed legislation that would alter the existing law that requires that a PA perform medical acts only as an agent of a specific licensed physician.

HOUSE OF DELEGATES ACTION — Recommendation four was amended and accepted by the Reference Committee to read, "that we request the Committee on Physicians' Assistants to continue its efforts in developing guidelines which may with the approval of the Executive Committee assist the Composite Board in its task of developing and redefining rules and regulations for Physicians' Assistants that are in agreement with the recommendations of the Reference Committee." The House then adopted each of the five Recommendations of the Reference Committee.

RESOLUTION 2
CHIROPRACTIC PRACTICES

Laurens County Medical Society

WHEREAS, assuring quality medical care for all patients is our collective and individual goal, and

WHEREAS, we have devoted a large portion of our lives in approved medical training programs preparing ourselves for the achievement of this goal, and

WHEREAS, we believe that chiropractic does not have a valid scientific basis, and

WHEREAS, chiropractors have not had approved medical training sufficient to render them capable of properly interpreting various laboratory, X-ray and physical findings, now, therefore, be it

RESOLVED, that chiropractors should not be allowed the use of in-hospital medical facilities, such as laboratory and X-ray, and be it further

RESOLVED, that radiologists should not be required to render X-ray interpretations to chiropractors, and be it

RESOLVED, that chiropractors should be prohibited from performing medical examinations, such as school athletic physical examinations.

REFERENCE COMMITTEE DISCUSSION

After considerable discussion, your Reference Committee felt the intent and sense of the resolution was to improve patient care, a goal which is highly laudable and consistent with AMA and MAG policies.

Your Reference Committee has restated the Resolution to clarify this intention and recommends that Resolution 2 be amended by deletion of the entire RESOLVED section and substitution of the following

RECOMMENDATIONS

1. "RESOLVED, that the use of in-hospital medical facilities such as laboratory and X-ray should be extended only to those qualified to utilize such facilities so as to maximize good patient care; specifically, this would include only doctors and osteopaths licensed under Georgia Code 84-9, and dentists and podiatrists licensed under Georgia Code Chapter 84 (to the extent of their licensed authority).

2. RESOLVED, that all medical examinations, such as school athletic physical examinations, should be performed only by practitioners licensed under Georgia Code 84-9.

Mr. Speaker, your Reference Committee recommends that the revised RESOLVED paragraphs 1 and 2 be adopted.

HOUSE OF DELEGATES ACTION — Recommendations one and two were amended by the House of Delegates to read: Recommendation 1 — RESOLVED that the use of in-hospital medical facilities such as labo-

ratory and x-ray should be extended only to those qualified to utilize such facilities so as to maximize good patient care. Specifically, this would include only doctors and osteopaths licensed under Georgia Code 84-9 as defined at this date and dentists licensed under Georgia Code 84-8 (to the extent of their licensed authority) as defined at this date. Recommendation 2 — RESOLVED that all medical examinations, such as school athletic physical examinations, should be performed only by practitioners licensed under Georgia Code 84-9 as e 84-9 as defined at this date. Both Recommendations as amended were adopted.

RESOLUTION 10
HOSPITAL PATIENT RECORDS

Medical Association of Atlanta

WHEREAS, the patient's record in U.S. hospitals has been a source of information for the physician who is responsible for the care given the patient as well as for the retrieval of data for research and review projects, and

WHEREAS, many allied health workers have begun the process of recording their observations in the section of the hospital chart known as the "Doctor's Progress Notes," to the detriment of clarity and continuity of the progress notes recorded by the physicians, and

WHEREAS, voluminous, repetitive, and sometimes needless notes in the patient's records by allied health personnel are often allegedly justified by citing standards of the Joint Commission on Accreditation of Hospitals (JCAH), or suggestions made by JCAH survey team members, and

WHEREAS, the JCAH does not require the inclusion of notes by allied health personnel in the "Doctor's Progress Notes" section, now, therefore, be it

RESOLVED, that the MAG go on record favoring the position that only M.D.'s or their employed extenders place notes in the section specified as "Doctor's Progress Notes," and all other notes be placed in other areas of the chart as specified by the hospital medical staff and administration as appropriate for that purpose, and be it further

RESOLVED, that upon adoption, this resolution be forwarded to the AMA House of Delegates for their consideration, and if adopted, to call upon the JCAH to clarify their standards and control their survey teams' suggestions in conformity with this resolution.

REFERENCE COMMITTEE DISCUSSION

This Resolution addresses problems that occur when allied health workers utilize "Doctor's Progress Notes" in recording their observations. This Resolution promulgates the concept that only MDs or their employed extenders should utilize the section specified as "Doctor's Progress Notes." Mr. Speaker, your Reference Committee makes the following

RECOMMENDATIONS

1. That the first RESOLVED portion be amended to read as follows, "RESOLVED, that the Medical Association of Georgia go on record as favoring the position that, if a given hospital medical staff so chooses, only MDs, medical students, or MD-employed extenders place notes in the section specified as "Doctor's Progress Notes," and all other notes be placed in the other areas of the chart as specified by the hospital medical staff and administration as appropriate for that purpose.

Mr. Speaker, your Reference Committee recommends that this portion of the Resolution be adopted as amended.

2. The second RESOLVED requests that this Resolution be forwarded to AMA's House of Delegates for their consideration and if adopted, to call upon the JCAH to clarify their standards and control their survey teams' suggestions in conformity with this Resolution.

Mr. Speaker, your Reference Committee advises that the second RESOLVED be adopted.

HOUSE OF DELEGATES ACTION — Recommendation 1 was adopted as amended by the Reference Committee. The second Resolve was adopted as presented in the Resolution.

RESOLUTION 14
LEGAL AGE FOR PURCHASE OF ALCOHOL

William C. Collins, M.D.

WHEREAS, lowering of the drinking age from 20 to 18 has resulted in an increase in teenage problems in high schools, and

WHEREAS, this resulting drinking problem has increased the number of accidents and deaths among teenagers, and

WHEREAS, six states have raised the drinking age as a result of bills sponsored by the State Medical Societies in those states, now, therefore, be it

RESOLVED, that the MAG, in an effort to reduce the teenage alcoholism problem and related accidents and deaths, sponsor a bill in the 1980 Georgia General Assembly to raise the legal age for purchase of alcoholic beverages to age 20.

REFERENCE COMMITTEE DISCUSSIONS

Mr. Speaker, considerable evidence was presented to indicate that lowering of the allowable drinking age from 20 to 18 had resulted in increased teenage drinking problems of medical, psychological, and social proportions. It was learned that a bill to raise the drinking age to 20 is currently active in the legislature, although in an amended form. It was the opinion of the Reference Committee that this Resolution has considerable medical as well as social merit.

RECOMMENDATION

Mr. Speaker, your Reference Committee recommends approval of the Resolution 14 as stated.

HOUSE OF DELEGATES ACTION — Adopted Resolution 14 as presented.

RESOLUTION 20
PRIVATE PHYSICIANS' TREATMENT OF MEDICAID AND INDIGENT PATIENTS

Hugo S. Moreno, M.D.
B. F. Voljavec, M.D.

WHEREAS, there are certain Hill Burton hospitals in Georgia that are being pressed by various Legal Aid Societies and by the Department of HEW in providing not only emergency care but "adequate and undiscriminatory" follow-up care to indigent and Medicaid patients, and

WHEREAS, such pressure is being passed by some hospital administrations to their medical staffs asking them to provide free medical care in their offices or hospitals to those patients that need to be followed up after their initial treatment in the emergency room, or be subject to losing their hospital privileges, and

WHEREAS, such attitude is contrary to the principles of the AMA and MAG regarding the free private practice of medicine, now, therefore, be it

RESOLVED, that the MAG goes on record affirming the basic right of individual physician's freedom in the practice of medicine, subject only to the Ethical Principles of the AMA, and be it further

RESOLVED, that the MAG opposes requiring members of the private hospital medical staffs to treat patients free of charge or to subscribe to Medicaid contract as a condition for obtaining staff privileges, and be it further

RESOLVED, that the MAG continues supporting the principle that any bona fide emergency patient is entitled to adequate emergency medical care regardless of his ability to pay or his creed, sex, race, or national origin.

REFERENCE COMMITTEE DISCUSSION

Discussion of this Resolution resulted in the recognition by members of the Reference Committee that a variety of constraints are placed upon hospitals by government agencies, requiring certain minimums in the handling of indigent and Medicaid patients. It was thus incumbent upon the hospitals to transmit some of this responsibility to the medical staffs, and physicians may be placed in the situation of being required to treat indigent and/or Medicaid patients as a condition for maintaining their staff privileges.

Mr. Speaker, there are three paragraphs in the "RESOLVED" portion of this Resolution. The first and third of these paragraphs are in direct accord with AMA and MAG policy.

The second RESOLVED was felt by your Reference Committee to contain and evoke complex issues and that further study of this recently presented question is highly desirable before a final ruling is contemplated.

RECOMMENDATIONS

1. Mr. Speaker, your Reference Committee recommends that RESOLVES 1 and 3 be adopted.

2. Mr. Speaker, your Reference Committee advises that the second RESOLVE paragraph be not adopted but that the subject matter be referred to the MAG Board of Directors for further study.

HOUSE OF DELEGATES ACTION — Resolves 1 and 3 were adopted as recommended in Recommendation 1 of the Reference Committee. Delegate Robert Wells requested deletion of Resolve 2 of the Reference Committee and substitution of the following for the second Resolve of this Resolution: "RESOLVE that the MAG opposes requiring members of hospital medical staffs to treat any specific non-emergency patient or to subscribe to a Medicaid contract as a condition for obtaining or maintaining staff privileges." This substitute Resolve was adopted. Dr. Voljavec made an additional motion to direct MAG staff to inform all hospitals in the state of the action taken on this Resolution. This motion also passed.

RESOLUTION 6
MEDICAID PROVIDERS

Stephen C. May Jr., M.D.

WHEREAS, in the past, the MAG discouraged its membership from becoming providers under the Medicaid system, and

WHEREAS, the Medicaid Manual was modified to comply with MAG concepts, and



Delegates sit in on Reference Committee B discussions of issues and solutions regarding organized medicine.

WHEREAS, the MAG has not clarified its position insofar as its members becoming providers under the Medicaid system, and

WHEREAS, providers are in short supply in some portions of Georgia causing some hardship to those patients covered under the Medicaid system, and

WHEREAS, the MAG desires that all the citizens of Georgia obtain the highest and best medical care available, now, therefore, be it

RESOLVED, that the Board of Directors of the MAG recommend that as many of the members of the MAG as possible become providers under the Medicaid system insofar as is compatible with the members' philosophy and economic status.

REFERENCE COMMITTEE DISCUSSION

This Resolution makes note of the previous negotiation between the MAG and the Department of Medical Assistance regarding unacceptable aspects of the Medicaid system, particularly the Medicaid manual. The Resolution suggests that the manual was modified to comply with Medical Association concepts. However, the majority of those testifying on this point indicated continued dissatisfaction with the present form of the manual, implying that it continues to impose "cookbook" type of restraints upon physician judgement. The current resolution further urges that the MAG recommend that members become providers under the Medicaid system.

Mr. Speaker, your Reference Committee recommends that Resolution 6 be not approved. Instead, your Reference Committee makes the following

RECOMMENDATION

1. The current MAG policy of encouraging members to make their own decisions regarding Medicaid participation be continued.

2. Continued efforts to negotiate with the Georgia Department of Medical Assistance regarding revision of the Medicaid manual be carried out through appropriate channels, possibly by referral to the Committee on Third Party Relations.

3. Physician members of MAG are urged to continue in their long-established policy of voluntarily providing care to individuals regardless of financial or other status on the basis of medical need, with or without remuneration.

HOUSE OF DELEGATES ACTION — Voted not to adopt Resolution 6, but adopted in lieu thereof three recommendations made by the Reference Committee.

COMMITTEE ON LEGISLATION

James A. Kaufmann, M.D., Chairman

The 1979 Georgia General Assembly has ended and will go down in history as the longest legislative session in Georgia. This session began Monday, January 8, and ran through Wednesday, March 28. During this time, some 2,039 bills were introduced. Some 103 of these dealt with the health care delivery system. This was an increase of 23% over last year for the introduction of health care bills. If one can measure trends, then we can expect this number to increase due to the activity of our elected officials in state government trying to involve themselves in the practice of private physicians' offices throughout Georgia.

Several of the bills acted upon by the General Assembly this year were promoted initially by your Medical Association. Numerous other bills were introduced to which your medical society was in direct opposition and it was the charge of this Legislative Committee to try and defeat those bills to which MAG was opposed, and likewise to try and pass those bills which MAG supported. Several bills were introduced that MAG took no position on but watched closely for any adverse amendments which might be tacked on during the course of the 3-month legislative session.

Once again, I am proud to report to the membership that no legislation passed that MAG opposed. Several bills that MAG supported have not become law and are still active pieces of legislation and will be voted on next January. For this reason, it is of the utmost importance that all MAG members communicate their personal and the Association's viewpoints to our elected officials.

The following bills passed both the House and the Senate and are awaiting the Governor's signature to become law:

HB 55 The Patient Cost of Care Act

This bill creates a mechanism through the Department of Human Resources (DHR) for payment to DHR by persons and third-party payors for the care received.

HB 75 Pharmacy — Drugs — Prescriptions

Requires candidates taking the Georgia Pharmacy Examination to obtain supplemental courses certified by the School of Pharmacy after failing the examination administered by the State Board of Pharmacy three times; adds additional drugs to Schedule II of the Controlled Substances Act; makes it unlawful for any practitioner to issue any prescription document signed in blank. The issuance of said document signed in blank, other than in the possession of the signee, shall be prima facie evidence of a conspiracy to violate the provisions of the Georgia Pharmacy Act. MAG supported.

HB 173 Georgia Post-Mortem Examination Act

Initiated by MAG, this bill increases the medical examiner's fee from $35 to $50 where dissection of the body is not required; from $110 to $175 where dissection of the body is required; and from $150 to $250 where a complete post-mortem examination and autopsy is performed. MAG supported.

HB 188 Alcoholism Intoxication Treatment Act

Postpones the effective date of this Uniform Alcoholism and Intoxication Treatment Act of 1974 until July 1, 1980. MAG supported.

Reference Committee B

HB 287 Guardians — Mentally Ill, Mentally Retarded

Provides that the probate court shall appoint a guardian for those persons who are incompetent of managing their personal affairs if they are mentally ill or mentally retarded. If no guardian is available, the court may appoint the Director of the Department of Family and Children Services in the county where the person resides to serve as guardian.

HB 292 Ambulance Services — Emergency Medical Technicians

Amends the Ambulance Services Act relative to emergency medical technicians and provides that advanced emergency medical technicians may render any service for which they are authorized under their certification act in any hospital. Such services shall not be rendered in lieu of the services of a physician or a licensed professional nurse and may only be rendered in a hospital at the discretion of the hospital governing authority on the order of a physician or if a physician is present, at the direction of a physician.

HB 312 Provisional Medical Licenses

Provides, by law, that no person may receive a provisional medical license to practice medicine in this state if said applicant fails three times any examination which is required to be passed to become a licensed practitioner in this state. Said applicant shall not be eligible to retake any such examination until such applicant furnishes proof of having completed 1 year of appropriate education and training as approved by the Composite State Board of Medical Examiners. MAG supported.

HB 691 Indigent Persons Health Care Costs Payments

Establishes a mechanism for the creation of "Non-Resident Indigent Health Care Fund." This state-appropriated fund would be disseminated to public hospitals throughout Georgia which provide care to indigent patients that do not reside in the county of said hospital. This obviously would relieve the tax burden of those persons residing in the county of the hospital for care rendered to non-taxpayers of that county. MAG supported.

HB 705 Immunization — School Children

Requires that no child be admitted to a public school unless such child shall first be immunized from contagious diseases itemized by DHR; provides for a provisional certificate to be granted for a period not to exceed 30 days; provides that on the grounds of religious beliefs, this section may be waived.

HB 774 Georgia Medical Assistance Act

Establishes by law a mechanism requiring third-party payors to pay all or any part of the medical cost incurred by a recipient of medical assistance on account of any sickness, injury, disease, or disability to such a recipient.

HR 171-710 Joint Emergency Medical Services Study Committee

Creates said committee for the purpose of studying existing laws and rules and regulations regarding ambulances and emergency medical services. Regulations regarding staffing of ambulance personnel, etc., are subject to change monthly by the Board of Human Resources. This newly created committee hopefully will have input into proposed changes regarding services of ambulances throughout the state. MAG supported.

SB 33 Consumers — Composite State Board of Medical Examiners

Enlarges the membership of the Composite State Board of Medical Examiners from 12 to 13 and provides that this one additional member shall be a citizen member, non-medical doctor, appointed by the Governor, and may only vote on matters relating to administration and policy which do not directly relate to practical and scientific examination of physicians in this state.

SB 40 Certificate of Need

Provides that all health care facilities other than offices of private physicians or dentists must obtain a Certificate of Need from the State Health Planning and Development Agency prior to construction or expansion or alteration of said facility, be it purchase of equipment, etc., in excess of $150,000. Creates authority for the Statewide Health Coordinating Council which is to review and approve rules and regulations, etc., of the State Health Planning and Development Agency. Establishes an appeals mechanism for Certificates that are denied. Requires that when a Certificate of Need is applied for, and said application is not acted upon in due time, then said Certificate is automatically granted.

Exclusions under this act are: (1) infirmaries operated by educational institutions for the sole benefit of students and faculty; (2) infirmaries or facilities operated by businesses for the sole benefit of officers and employees thereof; (3) institutions operated exclusively by the federal government; (4) offices of private physicians or dentists, whether for individual or group practice; (5) Christian Science sanitoriums operated and certified by the First Church of Christ, Scientists; (6) site acquisitions for health care facilities for health maintenance organizations; (7) expenditures related to adequate preparation and development of an application for a Certificate of Need; (8) the commitment of funds conditioned upon the obtaining of a Certificate of Need; and (9) expenditures by a health care facility for capital improvements or health services which are required to render such facility in compliance with the requirements of state or federal laws or regulations.

SB 69 "Doctor" or "Dr." Advertising

Amends the law passed in 1978 requiring each individual who uses the term "Doctor" or "Dr." in conjunction with his name in any letter, business card, advertisement, sign, public listing, display or circular of any nature

to designate behind his name the degree or lack of for which he uses "Doctor" or "Dr." and specifically excludes the use of this in a corporate charter.

SB 162 Health Maintenance Organizations (HMOs)

This bill provides for the regulation and control of persons, firms, or corporations that provide certain health care services and who offer certain health care benefits plans. This bill establishes through the Georgia Insurance Commissioner and through the DHR the total operations and health care services rendered by HMOs. It provides that governing bodies of such organizations shall include providers and at least one third public members; provides that the DHR in coordination with existing law of this state assures the public that said HMOs are providing quality care to its enrollees.

Prior to the enactment of this law, HMOs could and were being established in Georgia under interpretation of federal rules and regulations without any state law regulating their activities. The passage of SB 162 only establishes Georgia laws pertinent to the licensure and control of HMOs.

SB 163, SB 164, SB 165 Hospitalization and Treatment of the Mentally Ill, Mentally Retarded, and Alcoholics

As a package, these bills amend laws passed in 1978 relative to the hospitalization and treatment of the mentally ill, the mentally retarded, and alcoholics. This bill defines facilities, defines community mental health centers, defines commitment processes, and provides for the coordination of state benefits for persons who are mentally ill, mentally retarded, or alcoholics. MAG supported.

SB 196 Maternal and Infant Health Council

Amends existing law to increase the size of said Council to 17 persons with representatives of the general public and an equal number of obstetricians, pediatricians, family practitioners, and consumers. It shall also include one nurse, one hospital administrator, one public health physician, and one educator. MAG supported.

SR 13 Senate Health and Medical Education Study Committee

This committee, comprised of the Chairman of the Higher Education Committee, the Chairman of the Agriculture Committee, the Chairman of the Appropriations Committee, the President Pro Tempore of the Senate, the Chairman of the Senate Human Resources Committee, and five other members of the Senate, shall undertake a study of the problems of a serious shortage in the numbers of trained and available doctors, nurses, dentists, and veterinarians in this state. The purpose of this committee is to take appropriate steps to determine what might be done to ease the serious shortage and to coordinate efforts aimed at such an undertaking and to assure that funds for training such professional personnel are spent in a wise and efficient manner.

SR 185 Georgia Voluntary Effort for Cost Effectiveness

This resolution commends the Georgia Voluntary Effort for Cost Effectiveness in health care by commending the Georgia Hospital Association, the Federation of Georgia Hospitals, the MAG, Governor Busbee's office, Blue Cross-Atlanta, Blue Cross-Columbus, and the Health Insurance Association of America for having jointly created and sponsored the Georgia Voluntary Effort for Cost Effectiveness in health care in an effort to reduce the increase in health care costs in this state. MAG supported.

The following bills did not pass this year but are subject to passage or defeat in the 1980 session:

HB 63 Emergency Care — Liability

Amends the Good Samaritan Act by expanding those persons who are immune from liability for rendering emergency care from just physicians licensed under Code Chapter 84-9 (Medical Practice Act) to also include nurses, firemen, civil defense workers, Red Cross workers, law enforcement personnel, and those certified in cardiopulmonary resuscitation. This bill passed the House and is pending before the Senate Judiciary Committee.

HB 83 Mental Illness Insurance

This bill, which passed the House Insurance Committee and will be voted on by the entire House next year, requires that all accident and sickness insurance policies, both group and individual, shall be required to make available coverage for the treatment of mental disorders, which is at least as extensive and provides at least the same degree of coverage as that policy or contract for the treatment of other types of physical illnesses. MAG supports.

HB 122 Voluntary Sterilization Act

As introduced and passed the House of Representatives, this bill amends the Voluntary Sterilization Act by reducing the age requirement from 21 to 18; by removing spouse consent prior to sterilization; and by removing the requirement for second physician consultation prior to sterilization. MAG supported the original HB 122.

The Senate Special Judiciary Committee altered this bill by restoring age 21, by requiring a request in writing be made prior to the sterilization procedure, and "in non-emergency or elective situations, 30 days have elapsed from the time of the written consent before performance of the sterilization procedure." No action was taken by the entire Senate on this committee substitute to HB 122.

HB 139 Catastrophic Health Care Costs

Assigned to a special study committee of the House Insurance Committee for the purpose of re-writing. The concept of HB 139 is to assure the availability of health insurance coverage for eligible expenses which exceed a

catastrophic threshold in any 1 year to residents of this state. This would provide a means for state residents to protect themselves against the extraordinary cost of serious illness or injury and would provide a system insuring the availability of such protection to persons unable to purchase such insurance protection, either on an individual or group basis, directly from an insurance carrier. MAG supports.

HB 228 Chiropractic Insurance

Pending vote by Senate Banking, Finance, and Insurance Committee, HB 228 provides all group and blanket insurance policies of accident and sickness insurance to provide coverage for services which are within the lawful scope of practice of a duly licensed chiropractor in this state and shall be deemed to provide that any person covered under such policy or contract shall be entitled to receive reimbursement for such services under such policies or contracts, regardless of whether they are rendered by a duly-licensed doctor of medicine or a duly-licensed chiropractor. MAG opposes.

HB 394 Optometric Use of Drugs

Identical to SB 44 which provides that optometrists could use pharmaceutical agents for diagnostic purposes. Pending before the House Health and Ecology Committee. MAG opposes.



HB 472 Smoking in Public Places

Pending vote by the entire House, this bill would require that a person who shall smoke tobacco in any form in a hospital or health care institution, except in a private room or in any private administrative office or in a clearly designated smoking area or in nursing homes, shall be punished by a fine not less than $10 and not more than $100. Each hospital or health care institution, except nursing homes, shall post at each public entrance a sign containing the following in bold letters: NO SMOKING.

HB 553 Immunity — Peer Review Protection

This bill having passed the House and pending vote before the entire Senate provides protection for those individuals who are members of peer review groups which evaluate quality, efficiency, and professional health care providers and to protect the confidentiality of their records. MAG supports.

HB 599 Canadian Medical Graduates

The original HB 599 waived the 1-year Georgia residency requirement for those persons who have graduated from accredited Canadian medical schools. This waiver would enable the Composite State Board of Medical Examiners to grant a medical license to those persons who have graduated from approved and accredited Canadian medical schools. A Senate amendment to this bill added an extension of the "Fifth Pathway" program requiring by law the Medical College of Georgia to accept those persons leaving foreign medical schools to come into the Georgia system to obtain a medical license.

MAG supported the original HB 599 and opposes the "Fifth Pathway" portion. This bill did not become law this year.

HB 652 Definition of Physician

This bill passed the House and is pending vote by the Senate Human Resources Committee. HB 652 restricts the word "physician" to only those persons licensed under Georgia Code Chapter 84-9, the Medical Practice Act, or MD's, and osteopaths. MAG initiated and supports.

HB 688 State Crime Laboratory

This bill amends Georgia Bureau of Investigation (GBI) Act to provide for the State Crime Laboratory as a separate division within the GBI to be known as the Division of Forensic Sciences. This bill further states that the director of this division shall be designated as the Chief Medical Examiner of the State of Georgia. This bill is pending vote before the entire House of Representatives.

HB 885 Fifth Pathway Program

Would extend from 3 to 6 years the requirement that the Medical College of Georgia develop and offer a clinical training program for the purpose of accepting students from foreign medical schools. The MAG, the Composite

State Board of Medical Examiners, and the Medical College of Georgia are in opposition to this bill.

HB 1044 Commissioner, Department of Human Resources

This bill amends the Executive Reorganization Act of 1972 authorizing the Governor to appoint the Commissioner of Human Resources and requires the Commissioner of Human Resources to be elected by the people of Georgia in the same manner and at the same time as the elected constitutional executive officers of this state. This would be a 4-year term of office prior to re-election.

HB 1067 Georgia Health Services Cost Review Commission Act

This independent commission, functioning within the DHR and appointed by the Governor, shall have the jurisdiction and powers which extend to all hospitals, health care, and related institutions as defined by law, whether they be operated as profit-making or nonprofit-making institutions. This commission would compile all relevant financial and accounting data in order to have available the statistical information necessary to properly conduct rate review and approval. The commission would (1) permit any nonprofit institution to charge reasonable rates which will permit the institution to render effective and efficient service in the public interest on a solvent basis, and (2) permit any proprietary profit-making institution to charge reasonable rates which will permit the institution to render effective and efficient service in the public interest and which shall include sufficient allowance for and provide a fair return to owners based upon fair value of the institution's property and investments directly related to the health facility.

HR 90 Birth Defects — Responsibility

A repercussion from the New York Court of Appeals which ruled that a physician could be held liable for damages if a child is born deformed or with birth defects, if the physician had not disclosed to the prospective parents the likelihood or possibility that said child conceived by them may be born in a deformed condition or with birth defects. MAG opposes.

SB 9 Hospitalization of the Mentally Ill

Amends current law to state "mentally ill person requiring involuntary treatment means a person who is mentally ill and, (1) who presents a substantial risk of imminent harm to himself or others as manifested by either recent overt acts or recent expressed threats of violence which present a probability of physical injury to himself or to other persons, or (2) who is unable to care for his own physical health and safety."

SB 11 Spinal-Cord Disabled Persons

This bill would require all physicians and others to notify the DHR of all persons who are spinal-cord disabled. Spinal-cord disabled means any spinal cord disease, injury, or neural tube defect, whether congenital or acquired, which results in partial or total loss of motor or sensory functions and which results in partial or total disability whether such disability is temporary or permanent.

SB 12 Community Services Act for the Mentally Handicapped

This bill acknowledges that the State of Georgia accepts a responsibility for its mentally handicapped citizens and has an obligation to them which it must discharge, a pattern of facilities, programs, and services shall be made available to meet the needs of each mentally handicapped person during his entire lifetime. The primary purpose of this Act shall be to provide community alternatives to total institutional care so that mentally handicapped individuals can continue to live in their home communities.

SB 44 Optometric Use of Drugs

Would permit optometrists in this state to use pharmaceutical agents for diagnostic purposes in the practice of optometry. MAG opposes.

SB 50 Vocational Rehabilitation

This bill would create a separate Department of Vocational Rehabilitation (DVR). This new DVR would have its own commissioner and be outside the administrative control of the DHR.

SB 86 Life-Sustaining Procedures

This bill would provide Georgians an opportunity to initiate a "Directive to Physicians" indicating their desire for the physician not to employ or to remove life-sustaining measures under certain conditions. MAG supports.

SB 95 Clinical Social Work Practice Act

Create a new Board for the licensure and regulation for the practice of clinical social work. Clinical social work is a professional service distinguished by its traditional focus on personal strengths, personal relationships, and the interaction of the individual with his or her environment. It is not dictated by professional setting but rather is a body of knowledge developed to effect change in human behavior, emotional responses, and social conditions of individuals, couples, families, groups, organizations, and communities, etc.

SB 169 Psychology Insurance

SB 169 has passed the Senate and is pending before the House Insurance Committee. It would require each insurance company which offers accident and sickness insurance in this state, and provides major medical insurance coverage, to affirmatively offer in such major medical insurance policies, coverage for those services which an applied psychologist is authorized to render and those services which a psychiatrist is authorized to render under Georgia Code Chapter 84-9 relating to medical practitioners.

SB 217 In-Patient/Out-Patient Insurance

This bill, currently being studied by the Senate Banking, Finance, and Insurance Committee, would require insurance companies to reimburse for medical procedures performed on an out-patient to the same degree as said medical procedures are performed on an in-patient. MAG supports.

REFERENCE COMMITTEE DISCUSSION

The extensive report by the Committee on Legislation was received and studied by the Committee. The heartening fact that no legislation passed which MAG opposed was brought out and applauded. The body of this report is commended to the membership of the House of Delegates as of prime importance to all concerned. The endless and tireless work of Rusty Kidd and of Dr. James Kaufmann is regarded by the Committee as a continuing phenomenon without which the main business of the MAG could not go forward.

RECOMMENDATION

Mr. Speaker, your Reference Committee recommends the acceptance of this report for information with enthusiastic commendation of its authors.

HOUSE OF DELEGATES ACTION — The Recommendation of the Reference Committee was adopted.

SUPPLEMENTAL REPORT TO THE REPORT ON LEGISLATION

James A. Kaufmann, M.D., Chairman

The December Board meeting of MAG directed your Legislative Committee to work for the enactment of a law which in some way would prohibit the continued formation of rural health clinics formed by the DHR and others without direct physician supervision. If this were accomplished, it would delete the blanket authority of physician extenders without proper supervision, be it either on a patient by patient basis or daily eyesight or communication.

Research revealed that current laws relative to Georgia Pharmacy Acts, Georgia Code 79-A, and the Rules of the Georgia State Board of Pharmacy are explicitly clear in defining who, and only who, can write a prescription, sign a prescription, and authorize prescriptions. These laws are also explicitly clear in the use and administration of all drugs, including distribution of sample drugs.

The attorneys for the MAG, Powell, Goldstein, Frazer & Murphy, and the Georgia State Board of Pharmacy Drugs and Narcotics Agency agree in the following interpretation of existing Georgia laws relative to drugs:

1. "Physician" shall mean an individual licensed to practice medicine in accordance with the provisions of Georgia Code Chapter 84-9, the Medical Practice Act.
2. "Practitioner" or "Practitioner of the healing arts" shall mean a physician, dentist, or veterinarian and shall include any other person licensed under the laws of this state to use, mix, prepare, dispense, prescribe, and administer drugs in connection with medical treatment to the extent provided by the laws of this state.
3. "Prescription" shall mean an order for drugs or devices written, signed or transmitted by word of mouth, telephone, or telegraph, by a practitioner of the healing arts or other medical practitioner licensed to write prescriptions intended for the treatment or prevention of disease of man or animals, or in the discretion of the dispensing pharmacist, by a medical doctor licensed under the laws of the state other than the State of Georgia.
4. All prescriptions must be signed at the time they are written by the prescribing physician. (No pre-signed prescription blanks are permissable.)
5. All sample drugs must contain the following on each and every sample package:
 a. the name of the patient
 b. the name of the physician
 c. the date the sample is given
 (Note: "Federal laws prohibit dispensing without prescription" appears on practically all sample packages. Therefore, all samples, when delivered to the patient, are to be treated as a prescription item.)
6. No one other than those persons licensed and defined as a practitioner or practitioner of the healing arts (physician, dentist, veterinarian, or others licensed to prescribe medications) can legally sign a prescription or telephone or communicate the origination of a prescription to a licensed pharmacy in this state.

The Legislative Committee of the MAG presented to the Executive Committee of this Association the above six items and stated it was our opinion that with the enforcement of the above, rural health clinics and satellite clinics, etc., would be of little or no value without a physician being directly involved in the prescribing process of all prescription drugs. Hence, we were of the opinion, and recommended to the Executive Committee, that no new legislation be introduced at this time. We also recommended that the Executive Committee inform the membership of MAG as to the existing laws and urge our membership to familiarize themselves with the laws of this state regarding the use of prescription medications and alter their prescribing practices should any be at variance with the law.

RECOMMENDATIONS

1. Inform the membership of MAG, through all possible media mechanisms, the MAG *Newsletter*, the *JMAG*, direct mail, etc., of the above Georgia laws relative to the prescribing, writing, signing, sampling, and distribution of all drugs under the control of the Georgia Pharmacy Act.

2. Work with the Georgia Board of Pharmacy and the Georgia Pharmaceutical Association informing all pharmacists in Georgia of the laws of this state regarding who

is authorized to write prescriptions and call in prescriptions for the patients of this state.

3. After ample time for education of our members, work with the Georgia State Board of Pharmacy and others to enforce the existing laws of this state relative to prescribing drugs.

REFERENCE COMMITTEE DISCUSSION

This important report describes the sequence of events which occurred after the Committee on Legislation was directed by the Board of MAG to work for the enactment of a law which in some way would prohibit the continued formation of rural health clinics created by the DHR and others, which continued to function without direct physician supervision.

It was the feeling of the Committee on Legislation that existing laws, specifically Georgia Pharmacy Acts (Georgia Code 79-A), were already clear in defining who may order drugs and write prescriptions. It was recognized by the Committee on Legislation as well as your Reference Committee that several levels of participation by nurses and other physician extenders may come into play in the process of writing prescriptions or communicating prescriptions by telephone. Specifically, these levels could include: (1) the unattended nurse or PA; (2) the nurse practicing "protocol" medicine; (3) the nurse simply communicating a physician's prescription by telephone; and (4) the physician communicating the prescription in person. In spite of this possible stratification, and in spite of the time necessarily expended by a physician in personally communicating every prescription to the pharmacist, it was the opinion of those most knowledgeable in the area, including MAG legal counsel, that current Georgia law requires that every such prescription contact be carried out personally by the physician.

The Legislative Committee feels that enforcement of this existing legislation will constitute a firm bar for continued formation of independently operating health clinics functioning without direct physician supervision.

The three recommendations contained in this report would sequentially inform the membership of the MAG, encourage action by the Georgia Board of Pharmacy, and encourage enforcement of the existing law.

RECOMMENDATIONS

Mr. Speaker, your Reference Committee urges adoption of these recommendations as specified below:

1. Inform the membership of MAG, through all possible media mechanisms, the MAG *Newsletter*, the *JMAG*, direct mail, etc., of the above Georgia laws relative to the prescribing, writing, signing, sampling, and distribution of all drugs under the control of the Georgia Pharmacy Act.

2. Work with the Georgia Board of Pharmacy and the Georgia Pharmaceutical Association informing all pharmacists in Georgia of the laws of this state regarding who is authorized to write prescriptions and call in prescriptions for the patients of this state.

3. After ample time for education of our members, work with the Georgia State Board of Pharmacy and others to enforce the existing laws of this state relative to prescribing drugs.

HOUSE OF DELEGATES ACTION — Adopted Recommendations 1, 2, and 3 as represented by the Committee on Legislation and reiterated by the Reference Committee.



Mr. Dick Vincent, MAG's attorney, answers legal questions before the House. In background, L-R, Drs. Carson Burgstiner, Earnest Atkins, Milton Johnson.



Lolan Inman Brown, Mr. James M. Moffett (MAG staff), and Dr. William D. Logan Jr. sit in on House action.



Drs. William R. Hardcastle, Dan Stephens, William Huger Jr., and Mr. L. B. Storey listen to budget discussion in Reference Committee F.

Report of Reference Committee F

WILLIAM E. HUGER, M.D., Chairman

Chairman Huger reported that members of Reference Committee F met in the James Madison Room at the DeSoto Hilton Hotel in Savannah, Georgia, on Friday, April 20, 1979, and carefully considered all items referred to the committee. Physicians on this reference committee included: William E. Huger Jr., Atlanta; Stuart H. Prather Jr., Augusta; William R. Hardcastle, Decatur; Cyler D. Garner, Gordon; George W. Merritt, Vidalia; and Dan B. Stephens, Marietta.

Mr. Speaker, your Reference Committee submits the following report with the request the entire report be heard before discussion of any of its three component parts.

COMMITTEE ON PRISON HEALTH CARE

J. Rhodes Haverty, M.D., Chairman

This committee's function continues to be providing guidance and input to MAG's Program to Improve Health Care in Jails, a subcontract from the AMA, which is completing the third year of the pilot project.

The third year witnessed the continuation and acceleration of the AMA's Accreditation Program of Medical Care and Health Services in Jails, using the Standards that were developed and tested in the first 2 years of the project. Ten new jails participated in the program in addition to three of the five original pilot jails. Four have been awarded accreditation by the AMA to date. Committee members have continued to participate in the accreditation process as members of the site visit teams, and the committee serves as a review and recommendation body to the AMA National Advisory Committee.

Requests from all over the country have been received concerning the Receiving Health Screening course for jail personnel that was developed under the sponsorship of this committee. A presentation concerning this course was made at the AMA's Second National Conference on Medical Care and Health Services in Correctional Institutions in Chicago in October.

As the final year of external funding for the pilot project ends, the AMA has repeatedly reaffirmed its commitment to the continuation of this endeavor. The MAG may be asked to assist in the support of the program as it has done for the past year. The committee has demonstrated its sincere commitment to the program's goals. Real progress has been made in our state in improving health care in city and county jails through our efforts. We believe that the MAG must continue its active involvement in this cause as an obligation the medical profession has to the community.

We were informed in mid-March 1979 that the AMA has approved additional funds in the amount of $46,000 for the MAG to continue its activity on this project.

SUPPLEMENTAL REPORT

Information received from the AMA on April 5, 1979, indicates that the AMA will continue funding the current year's activity until May 31, 1979, at the present level of funding. A new subcontract to continue technical assistance in the local jails is to begin for 1 year on June 1, 1979. The total budget for the fourth year, according to AMA, is $43,650. Of this amount, $39,285 is to be funded by the AMA, and a matching amount of $4,365 from the MAG has been requested by the AMA.

REFERENCE COMMITTEE DISCUSSION AND RECOMMENDATION

Mr. Speaker, your reference committee has carefully considered the Report on Prison Health Care and the Supplemental Report. We recommend that they be adopted as submitted and that the AMA request for matching funds in the amount of $4,365.00 be granted. The basis for this recommendation is that, to the reference committee's satisfaction, the residual from previous AMA funding and HSA funding plus the secretarial services already agreed to and supplied by the MAG more than covers the requested matching funds without alteration of the budget.

Reference Committee F commends the Committee on Prison Health Care for its activities to date and recommends that the committee continue its activities as a function of the MAG.

HOUSE OF DELEGATES ACTION — Adopted the report of the Committee on Prison Health Care and the Supplemental Report of the Committee on Health Care as submitted.

OFFICE OF THE PRESIDENT

Carson B. Burgstiner, M.D., President

As the year of my presidency comes to a close, I am able to look back on a year filled with challenges and am very proud to report that the Medical Association of Georgia has represented you well. I know of no finer state organization anywhere.

The MAG is in the best financial condition in its 130-year history. Its membership is the greatest, its staff the largest, its influence the broadest, and its political clout the most impressive.

We have experienced a year of HMOs, IPAs, PAs, nurse practitioners, Medicaid, Medicare, and Joseph Califano. And we have survived!

This year has been one of many problems. The year to come will present my successor, Ernie Atkins, with even more problems than we have experienced this year. I know he and his successors will meet the challenge.

It will not be possible in this brief report to list all the accomplishments of this past year. The record is before you in the minutes of the Executive Committee and Board of Directors, the reports of the other officers, and the reports of the various committees.

I would call to your attention the two primary goals that I had in mind as I began this year as President.

They were, first, unity of our profession. I called on all Georgia physicians to join together in spirit and mind and strengthen our Association.

We have come far but have even further to go. There are those among us who would splinter our organization, divide our strength, and frustrate our attempts to become the voice of medicine.

Let us not choose up sides and fight among ourselves! Let us join together to battle those who would seek to weaken the best health care system in the world. Let us define the enemy and make certain it is not ourselves! Let us seek out our fellow physicians who are not part of us and invite them in.

We in MAG now represent nearly 5,000 physicians in Georgia. Some 3,000 have also chosen to become a part of the AMA. These figures should make us proud, but we can do better.

The second goal of my presidency was in the field of nutrition. I cited a need that was not being met, and that was the establishment of an organized method to separate the wheat from the chaff, to establish a group to study the entire subject matter of nutrition and to find the truth.

A Nutrition Committee was appointed in May of last year headed by Dan Jordan who has performed most capably.

I know of no committee that has met more frequently, worked any harder, or has been more ambitious in defining its objectives and goals. I would strongly encourage you to read their report. We have begun the difficult task of educating medicine and the lay public alike in the importance and meaning of proper nutrition.

Your Medical Association of Georgia continues to be what you want it to be. We are expanding. This past year we employed Joyce Butler as Director of Medical Practice. Joyce came to us from CHAMPUS which she headed for 12 years.

We, in December, also added Bert Franco in the area of health planning. Both Joyce and Bert, I think, will add tremendously to our fine staff.

Tom Sawyer has become our Assistant Executive Director for Administration and in fact will be responsible for this upcoming meeting of the House of Delegates.

There are so many areas of MAG's involvement — legislative, public relations, health planning, continuing medical education, etc. Again, I encourage each of you to read and study the evidence of our accomplishments of this year which is presented in the various reports.

This year the Georgia Medical Care Foundation has officially separated from MAG, administratively at least, because it has now assumed the role as the Professional Standards Review Organization (PSRO) for Georgia. The new Executive Secretary is Bob Wesley. I urge each of you to give him your support and cooperation.

I cannot tell you how much I appreciate the honor of serving as your President. I trust my responsibilities have been discharged in a manner suitable to the office.

I wish to thank my fellow officers, the Executive Committee, and the Board of Directors for their tremendous cooperation in making my term as President a most enjoyable one.

I wish to thank those of you at the county society level for your encouragement, involvement, and assistance in making my tasks as President more pleasant.

And it goes without saying, a special thank you to the MAG staff without whose guidance and assistance the job of President would have been impossible.

SUPPLEMENTAL REPORT

RECOMMENDATION

Since the Board of Directors of the MAG is authorized by the Constitution of the Association to "have full authority and power of the House of Delegates between sessions of that body," it is recommended that the Board of Directors' Contingency Fund be spent from the Unrestricted Funds of the Association, rather than endeavoring to make this Contingency Fund a part of the annual budget of the Association.

This is an amount unknown at the time the budget is prepared, and the Finance Committee cannot put a cap on the amount the Board of Directors can spend during any fiscal period.

REFERENCE COMMITTEE DISCUSSION AND RECOMMENDATION

Mr. Speaker, your reference committee received the annual report of Carson B. Burgstiner, M.D., President, and commends him for its content. It should be noted that his Supplemental Report, when submitted to Reference Committee F had lines 13 through 16 already deleted and the report amended by the Treasurer to replace those lines as follows:

"This is an amount known, i.e., (Unrestricted Funds) at the time the Budget is prepared. For its use, the Board of Directors should be limited to 20% of the Unrestricted Funds of the MAG or if an amount in excess of this figure be needed, that excess amount be referred to the House of Delegates for approval."

Mr. Speaker, your reference committee recommends that the President's Supplemental Report be *not* adopted but amended to read, beginning line 7, as follows:

"It is recommended that the Board of Directors Contingency Fund be removed from the annual budget of the Association and that the Board of Directors' fiscal necessities be spent from the Unrestricted Funds of the Association to a limit of 10% of the Unrestricted Funds available on the terminating date of the last House of Delegates meeting. If funds in excess of this figure are needed, this excess amount must be referred to a called meeting or the next annual meeting of the House of Delegates for approval."

Mr. Speaker, your reference committee recommends that this Supplemental Report as amended be adopted.

Under the Constitution and Bylaws of MAG, although the Board of Directors has full authority and power of the House of Delegates between sessions, the Board is also obligated to carry out the mandates and policies of the House of Delegates. Accordingly, our legal counsel has advised that, if this recommendation is adopted, no further amendment to the Constitution or Bylaws would be necessary for it to be binding upon the Board of Directors.

HOUSE OF DELEGATES ACTION — Voted to adopt the Recommendation of the President as amended by the reference committee as follows: "Since the Board of Directors of the Medical Association of Georgia is authorized by the Constitution of the Association to 'have full authority and power of the House of Delegates between sessions of that body,' it is recommended that the Board of Directors Contingency Fund be removed from the annual budget of the Association and that the Board of Directors' fiscal necessities be spent from the Unrestricted Funds of the Association to a limit of 10% of the Unrestricted Funds available on the terminating date of the last House of Delegates meeting. If funds in excess of this figure are needed, this excess amount must be referred to a called meeting or the next annual meeting of the House of Delegates for approval."



BOARD OF DIRECTORS — BUDGET 1979-80

Joe C. Stubbs, M.D., Chairman

	Proposed Budget (when Different From Adopted Budget)	*Adopted Budget 6/1/79 thru 5/31/80*
INCOME		
Dues Collection	$ 900,000.00	$ 919,000.00
Interest and AMA Refund	56,000.00	60,000.00
Journal Advertising		51,000.00
Newsletter		3,000.00
Rental Income		47,250.00
Journal Subscriptions		5,000.00
TOTAL INCOME	$1,062,250.00	$1,085,250.00
EXPENSES		
Public Relations		$ 95,467.00
Continuing Medical Education	$ 78,165.00	80,440.00
Governmental Affairs		90,188.00
Journal		104,040.00
Legal Costs and Retainers		45,600.00
Legislation		92,055.00
Membership and Public Services	189,555.00	192,855.00
Management Services, Business and Finance		72,380.00
Association Activities	156,538.00	117,538.00
Building Costs	124,878.00	170,878.00
Information Systems (Computer)	12,300.00	9,000.00
TOTAL EXPENSE	$1,061,166.00	$1,070,441.00
Excess of Income over Expense	1,084.00	14,809.00
	$1,062,250.00	$1,085,250.00
PUBLIC RELATIONS		
Personnel Salary		$ 33,629.00
Fringe Benefits		5,429.00
Payroll Taxes		2,209.00
Telephone		15,500.00
Newsletter		4,200.00
MAGNET Conference		1,000.00
Travel		2,000.00
Public Relations		9,700.00
Constitution and ByLaws		—
Nutrition Study Committee		400.00
Postage		21,400.00
TOTAL PUBLIC RELATIONS EXPENSE		$ 95,467.00
CONTINUING MEDICAL EDUCATION		
Personnel Salary		$ 42,152.00
Fringe Benefits		6,949.00
Payroll Taxes		2,758.00
Scientific Assembly	$ 16,070.00	18,345.00
Education Committee		7,836.00
Travel		2,400.00
TOTAL CONTINUING MEDICAL EDUCATION	$ 78,165.00	$ 80,440.00

GOVERNMENTAL AFFAIRS

Personnel	$ 60,390.00
Fringe Benefits	9,083.00
Payroll Taxes	4,065.00
Travel	4,000.00
Composite Board of Medical Examiners	—
Cost Accountability	12,650.00
TOTAL GOVERNMENTAL AFFAIRS	$ 90,188.00

JOURNAL

Personnel	$ 23,600.00
Fringe Benefits	3,933.00
Payroll Taxes	1,425.00
Printing and Paper Cost	54,000.00
Photo Processing	250.00
Engraving and Cuts	600.00
Advertising Promotion	2,000.00
Postage and Copyright	4,420.00
Subscription	262.00
Clipping Service	350.00
Artwork and Supplies	3,050.00
Data Processing Services	500.00
Travel	650.00
Advertising Commission	9,000.00
TOTAL *JOURNAL* EXPENSE	$ 104,040.00

LEGAL COSTS — RETAINERS

Legal	$ 35,000.00
Insurance Actuary	7,000.00
Other (Franklin)	3,600.00
TOTAL LEGAL AND RETAINERS	$ 45,600.00

LEGISLATION

Personnel	$ 58,756.00
Fringe Benefits	9,369.00
Payroll Taxes	2,886.00
Legislative Expense	13,594.00
Travel	4,600.00
Legislative Bulletin	1,500.00
Liaison Board of Human Resources	600.00
Ad Hoc — Composite State Board of Med. Exam.	750.00
TOTAL LEGISLATION EXPENSE	$ 92,055.00

MEMBERSHIP AND PUBLIC SERVICES

Personnel	$ 42,343.00
Fringe Benefits	6,689.00
Payroll Taxes	2,811.00
WATS Line	4,700.00
Auxiliary — Health Careers	17,400.00
Roster	8,000.00
Travel — President	5,550.00
Travel — President-Elect	600.00
Travel — Past President	2,658.00

AMA Costs:		
Caucus Breakfast		1,300.00
MAG Headquarters Suite		2,200.00
Southeastern Coalition		1,500.00
Travel — Delegates and Alternates	$ 15,854.00	14,789.00
Travel — Officers		4,460.00
Interprofessional Council		125.00
AAMSA Contribution		500.00
AMSA to MAG Annual Session		300.00
AMSA Travel Cost		650.00
State Medical Education Luncheon		250.00
AMA Leadership Conference (2 MD's)		950.00
Disabled Doctors Program		50,800.00
Access to Health Care		2,500.00
Allied Health		5.00
Health Planning		500.00
Awards		1,200.00
Professional Liability Insurance		810.00
Prison Health Care	0.00	4,365.00
GaMPAC		5,000.00
Travel		4,000.00
MAG Foundation		4,200.00
Cost Accountability		—
Constitution and ByLaws		800.00
Physician-Lawyer Liaison		900.00
TOTAL MEMBERSHIP AND PUBLIC SERVICE	$ 189,555.00	$ 192,855.00
INFORMATION SYSTEM		
Computer	$ 12,300.00	$ 9,000.00
MANAGEMENT SERVICES, BUSINESS AND FINANCE		
Personnel		$ 30,365.00
Fringe Benefits		6,941.00
Payroll Taxes		1,894.00
Dues and Subscriptions		1,730.00
Data Base Maintenance		7,114.00
Audit		4,600.00
Office Supplies		8,000.00
Travel		2,100.00
Sundry — Flowers, etc.		300.00
Equipment Purchases		4,500.00
Xerox Maintenance		2,136.00
Payroll Computer		1,200.00
Retirement Trust Fee		900.00
Labels — Computer		600.00
TOTAL MANAGEMENT SERVICES, BUSINESS AND FINANCE		$ 72,380.00
ASSOCIATION ACTIVITIES		
Personnel		$ 47,277.00
Fringe Benefits		6,699.00
Payroll Taxes		2,934.00
Directors Contingent	$ 39,000.00	—
Executive Committee Contingent		5,000.00
Executive Committee Discretionary		5,000.00

Executive Committee Travel		3,800.00
Staff Travel		4,600.00
Car Allowance		3,408.00
Meetings		2,800.00
Annual Session		12,020.00
President's Contingency		24,000.00
TOTAL ASSOCIATION ACTIVITIES	$ 156,538.00	$ 117,538.00
BUILDING EXPENSE		
Personnel		$ 5,792.00
Fringe Benefits		904.00
Payroll Taxes		369.00
Maintenance:		
Building		7,000.00
Equipment		3,800.00
Taxes — Assets		13,600.00
Janitorial Services		10,100.00
Utilities		21,000.00
Building Insurance and Membership Insurance		6,000.00
Depreciation:		
Building		15,500.00
Equipment		22,735.00
Interest on Mortgage		16,728.00
Sinking Fund for Land Acquisition	$ 1,000.00	47,000.00
Travel		350.00
TOTAL BUILDING EXPENSE	$ 124,878.00	$ 170,878.00

REFERENCE COMMITTEE DISCUSSION AND RECOMMENDATION

Mr. Speaker, your Reference Committee has very carefully reviewed the Budget as submitted by the Chairman of the Board, mindful of the mandate of the House of Delegates that only a balanced budget be recommended for approval.

During the Reference Committee's detailed deliberations, it was established under Income, to the Reference Committee's satisfaction, that projected dues collection is expected to increase $19,000.00 and that projected Interest and AMA Refund is expected to increase $4,000.00 over and above the Board's expectation for the next fiscal year. We did not feel that we could rely on any anticipated increase in *Journal* Income and/or Foundation rental income. However, with the expected increase of $23,000.00, as noted above, we would amend the total Income figure in the Budget to $1,085,250.00.

Hearing requests from several sources for additional funds, our detailed deliberations led to the following Budget changes under Expenses:

1. Scientific Assembly increased $2,275.00.

2. Directors' Contingency Fund reduced $39,000.00.

3. Sinking fund for land acquisition increased $46,000.00.

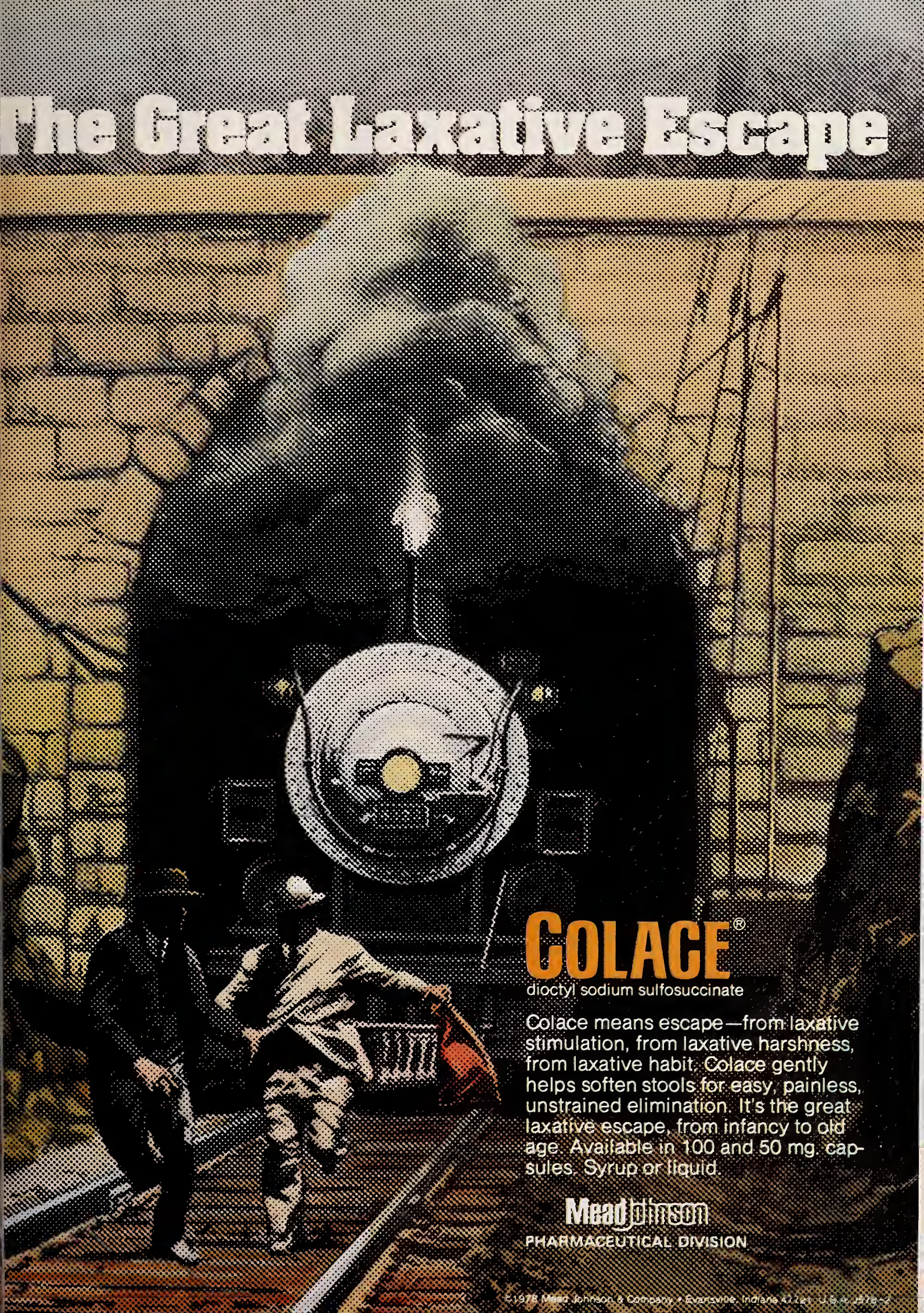
These budgetary expense changes allow amendment of the Association expense to $1,070,441.00, denying a deficit budget. The Reference Committee recognizes that the Board of Directors is expected to have expenses, but under this proposed fiscal plan these expenses would be drawn on a restricted basis from a nonbudgeted fund.

Mr. Speaker, your Reference Committee recommends that the Budget as submitted by the Chairman of the Board be *not* adopted, and that the Budget as amended by your Reference Committee be adopted.

HOUSE OF DELEGATES ACTION — Adopted the Report of the Board of Directors on the 1979-1980 budget with the changes as recommended by the Reference Committee.

Mr. Speaker, this concludes the report of Reference Committee "F," and I would like to thank all members of the Committee for their efforts on your behalf. We all want to thank our staff help, L. B. Storey, for his tireless efforts during and after our deliberations.

The Great Laxative Escape



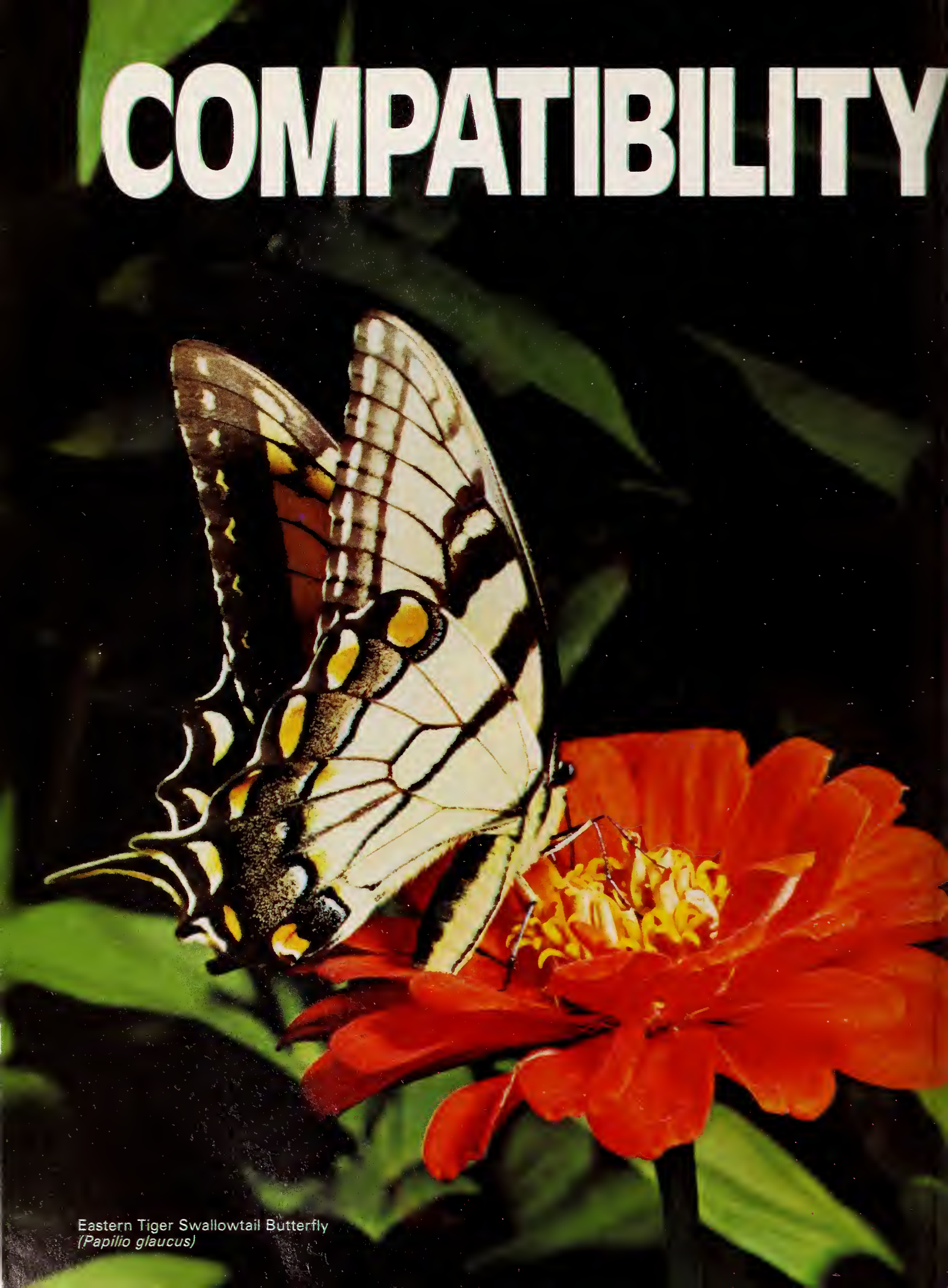
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COMPATIBILITY



Eastern Tiger Swallowtail Butterfly
(Papilio glaucus)

Does it influence your choice of a peripheral/cerebral vasodilator*?

Vasodilan–compatible with coexisting diseases (e.g., glaucoma, diabetes)

Vasodilan has not been reported to affect the course of coexisting disease; it has not been reported to affect blood sugar levels or to raise intraocular pressure.

Vasodilan–compatible with concomitant therapy

Vasodilan has not been reported to affect the treatment of coexisting disease; it is compatible with such drugs as hypoglycemics and miotics.

Vasodilan–compatible with your total regimen for vascular insufficiency

Vasodilan can be a valuable adjunct in planning a total therapeutic program for vascular insufficiency.

***Indications:** Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, the FDA has classified the indications as follows:

Possibly Effective:

1. For the relief of symptoms associated with cerebral vascular insufficiency.
2. In peripheral vascular disease of arteriosclerosis obliterans, thromboangiitis obliterans (Buerger's Disease) and Raynaud's disease.

Final classification of the less-than-effective indications requires further investigation.

Composition: Vasodilan tablets, isoxsuprine HCl, 10 mg. and 20 mg. Vasodilan injection, isoxsuprine HCl, 5 mg., per ml.

Dosage and Administration: Oral: 10 to 20 mg., three or four times daily. Intramuscular: 5 to 10 mg.(1 or 2 ml.) two or three times daily. Intramuscular administration may be used initially in severe or acute conditions.

Contraindications and Cautions: There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding.

Parenteral administration is not recommended in the presence of hypotension or tachycardia.

Intravenous administration should not be given because of increased likelihood of side effects.

Adverse Reactions: On rare occasions oral administration of the drug has been associated in time with the occurrence of hypotension, tachycardia, nausea, vomiting, dizziness, abdominal distress, and severe rash. If rash appears the drug should be discontinued.

Although available evidence suggests a temporal association of these reactions with isoxsuprine, a causal relationship can be neither confirmed nor refuted.

Administration of single dose of 10 mg. intramuscularly may result in hypotension and tachycardia. These symptoms are more pronounced in higher doses. For these reasons single intramuscular doses exceeding 10 mg. are not recommended. Repeated administration of 5 to 10 mg. intramuscularly at suitable intervals may be employed.

Supplied: Tablets, 10 mg., bottles of 100, 1000, 5000 and Unit Dose; Tablets, 20 mg., bottles of 100, 500, 1000, 5000 and Unit Dose; Injection, 10 mg. per 2 ml. ampul, box of six 2 ml. ampuls.

U.S. Pat. No. 3,056,836



VASODILAN® 20-mg tablets

(ISOXSUPRINE HCl)

20 mg q.i.d. recommended dosage

Mead Johnson

PHARMACEUTICAL DIVISION

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This asthmatic isn't worried about his next breath...



he's active
he's effectively maintained on

QUIBRON®

Each capsule or tablespoonful (15 ml) liquid contains theophylline (anhydrous) 150 mg and glyceryl guaiacolate (guaifenesin) 90 mg

- theophylline for effective around-the-clock bronchodilator therapy
- 100% free theophylline

Indications: For the symptomatic relief of bronchospastic conditions such as bronchial asthma, chronic bronchitis, and pulmonary emphysema.
Warnings: Do not administer more frequently than every 6 hours, or within 12 hours after rectal dose of any preparation containing theophylline or aminophylline. Do not give other compounds containing xanthine derivatives concurrently.
Precautions: Use with caution in patients with cardiac disease, hepatic or renal impairment. Concurrent administration with certain antibiotics, i.e., clindamycin, erythromycin, troleandomycin, may result in higher serum levels of theophylline. Plasma prothrombin and factor V may increase, but any clinical effect is likely to be small. Metabolites of guaifenesin may contribute to increased urinary 5-hydroxyindoleacetic acid readings, when determined with nitrosonaphthol reagent. Safe use in pregnancy has not been established. Use in case of pregnancy only when clearly needed.
Adverse Reactions: Theophylline may exert some stimulating effect on the central nervous system. Its administration may cause local irritation of the gastric mucosa, with possible gastric discomfort, nausea, and vomiting. The frequency of adverse reactions is related to the serum theophylline level and is not usually a problem at serum theophylline levels below 20 mcg/ml.
How Supplied: Capsules in bottles of 100 and 1000 and unit-dose packs of 100; Liquid in bottles of 1 pint and 1 gallon.
See package insert for complete prescribing information.

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- Community liaison and consultation
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Final General Session
Sunday, April 22

President Carson B. Burgstiner convened the Final Session of the 1979 Annual Session Business Meeting and expressed his appreciation to the speakers for their handling of the business of the House of Delegates.

Installation of Officers

Dr. Burgstiner asked the incoming president, the president-elect, the AMA Delegates and Alternates, Directors, and Alternate Directors to assemble in front of the Speaker's platform to take the oath of office as follows: President Earnest C. Atkins, Decatur; President-Elect H. Hilt Hammett Jr., LaGrange; First Vice President Richard A. Griffin III, Cartersville; Second Vice-President S. William Clark Jr., Waycross; AMA Delegate F. William Dowda, Atlanta; AMA Delegate C. Emory Bohler, Brooklet; AMA Alternate Delegate Carson B. Burgstiner, Savannah; AMA Alternate Delegate Charles D. Hollis Jr., Albany.

First District Director Leon E. Curry, Metter; and Alternate Director Douglas O. Cope, Statesboro; Second District Director J. Dan Bateman, Albany; and Alternate Director Sammie Dixon, Tifton; Third District Director V. M. McEver Jr., Warner Robins; and Alternate Director Ken Raynor, Warner Robins; Georgia Medical Society Director Joe L. Nettles, Savannah; and Alternate Director



President Burgstiner swears in new MAG officers: (L-R): Drs. Frank McKinnon, L. C. Buchanan, J. Harold Harrison, Joe Nettles, S. William Clark Jr., Earnest C. Atkins, Dan Baterman, H. Hilt Hammett Jr., C. Emory Bohler, and John P. Heard.

Clyde L. Olson, Savannah; Medical Association of Atlanta Director J. Harold Harrison, Atlanta; and Alternate Directors William C. Collins, Atlanta, and William C. Waters III, Atlanta. President Burgstiner administered the oath of office to the assembled new members of the MAG Board of Directors and declared these officers duly installed. Dr. Burgstiner then passed the gavel and medallion as the symbol of leadership to the incoming president, Earnest C. Atkins.

Dr. Atkins then presented to outgoing president Carson Burgstiner the MAG president's pin, a bound set of the *Journal* encompassing the Burgstiner presidential year, and a silver gavel appropriately inscribed.

Dr. Atkins announced the date and site of the MAG Annual Session — House of Delegates for the following 4 years as follows:

1980 — Atlanta, April 25-27, Atlanta Hilton Hotel
1981 — Columbus (or) Atlanta, April 24-26
1982 — Savannah, April 23-25, DeSoto Hilton Hotel
1983 — Jekyll Island, April 22-24, Holiday Inn

Dr. Atkins announced the official attendance at the 125th Annual Session as follows:

Delegates	184
Alternate Delegates	24
Members	39
Guests	32
Auxiliary	150
Total Registration	429

ADJOURNMENT

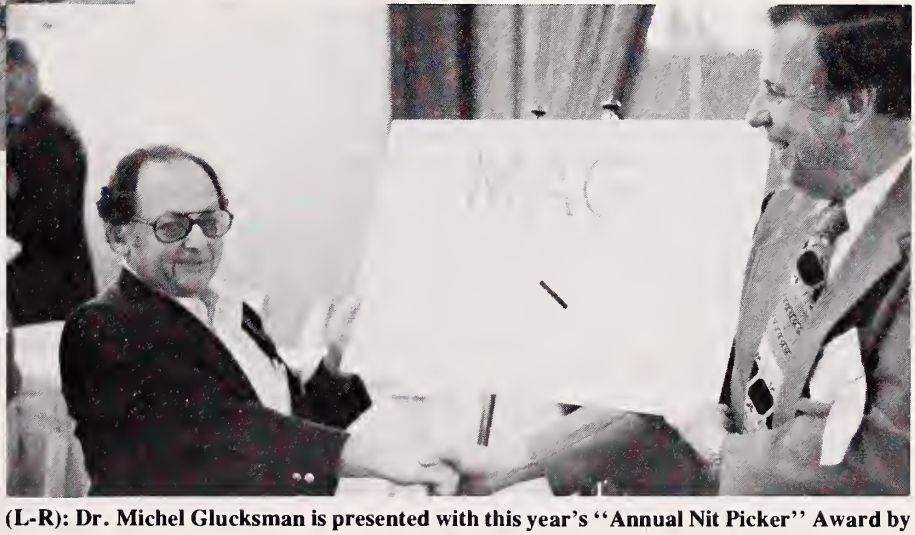
On motion duly made and seconded, Dr. Atkins adjourned the 125th Annual Session of the Medical Association of Georgia at 1:10 p.m.



(Above — L-R): Carson B. Burgstiner turns over the gavel and the MAG Presidency to Earnest C. Atkins.



(Above — L-R): Atchie Bryant (Mrs. Milton), Past President of the AMAG and Councilor to WA-SMA, and Donnie McDavid (Mrs. William), Past President of the Clayton-Fayette Auxiliary, wait *patiently* for the Final General Session to end.



(L-R): Dr. Michel Glucksman is presented with this year's "Annual Nit Picker" Award by Speaker L. C. Buchanan.

The Teenage Pregnancy Task Force in Chatham County

DARNELL L. BRAWNER, M.D., *Savannah**

TEENAGE PREGNANCIES pose serious economic, health, sociologic, and psychologic problems throughout our nation. This is a particularly serious problem in Chatham County, since we have probably the highest teenage pregnancy rate in the United States.

The Teenage Pregnancy Task Force of this region developed its program in three areas. The first expanded the reproductive education programs in the public school, the second encouraged and aided programs in the private schools, and the third informed the adults in this community about the problems spawned by teenage pregnancy.

The public school education program has been the most successful. An excellent course entitled "Maternal and Infant Care," encompassing reproductive function, has been taught to high school seniors and, with the complete cooperation of public school personnel, the course is being extended to the middle schools and the 6th grades. This is becoming a very popular course for both girls and boys.

The second area has been moderately successful. Some of the private schools have instituted similar programs in their curriculum and have used the expertise from the teachers in the public school program. However, many of the private schools have shown no interest in developing such a curriculum, and some have been antagonistic.

With respect to the third area of the program, that of informing adults, we have had excellent help from the media. Several television and radio programs have been devoted to this, and one particularly fine 30-minute documentary was presented by one of our local television stations. The Parent-Teacher Association has been very cooperative and sponsored a public meeting which presented a panel of experts. The meeting was well publicized and well attended.

We are in the process of developing a fourth area of the program which involves establishing guidelines for sexual responsibility. This is such a sensitive area encroaching on the moral values of our society, that we are approaching the development of such a program with extreme caution. We feel, however, without some type action here, we will be merely treating the symptoms and not eradicating the cause.

Come Help Us Celebrate The Child

St. Jude Children's Research Hospital continues its search for life-saving knowledge about catastrophic childhood disease. And this search continues because people care. There's no charge to patients or their families once admitted to its research studies by physician referral. The cost of drugs, equipment, and research programs is met primarily by public contributions. Help us celebrate the child by sending your tax-deductible check or request for further information to St. Jude Children's Research Hospital, 539 Lane Ave., Memphis, TN 38105.



ST. JUDE CHILDREN'S RESEARCH HOSPITAL
Danny Thomas, Founder

* Dr. Brawner is Chairman of Teenage Pregnancy Task Force for District 9.



Education — Not Regulation

Recently I reviewed a report, "Family Health in an Era of Stress."* The report clearly indicated that family members have real confidence in only one source of information — their own doctors — and recognized that the fight to curb inflation and medical costs is an intrinsic part of the battle to improve the health and health care of Americans.

Below are some ideas on how we can improve our patient's health without increasing the cost of medical care:

Nutrition — Spend the food dollar wisely.
Obesity — Sensible dieting.
Tension — Relieved by relaxation.
Immunization — Readily available.
Cigarette Smoking — 20% have quit.
Alcoholism — 8% drink too much.
Exercise — 36% do regularly.
Speeding — Save gas and lives by obeying the double nickel.
Seat Belts — 63% don't wear them.
Teenage and/or Unwanted Pregnancies — Abstain or contracept.
Venereal Disease — An ounce of prevention is worth a pound of cure.
Over-medication — Cut back on drugs.

A total of 77% of our patients have a lot of confidence in us; 22% have some confidence. Yet we cannot win them all, because 1% have no real confidence in us. What are the solutions?

First, let's educate ourselves.
Second, educate our patients.
Third, deregulate health care.
And finally, what's good for the goose is good for the gander — US!

Sincerely,

Earnest C. Atkins

Earnest C. Atkins, M.D.
President, MAG

* The General Mills American Family Report, 1978-79. General Mills, Inc., 9200 Wayzata Boulevard, Minneapolis, Minnesota 55440.

editorial
editorial
editorial

An Introduction of the New MAG Officers

THE CULMINATION of the 1979 Annual Session was marked by the installation of the newly-elected officers of the Association. Brief biographical sketches are presented below to acquaint you with the excellent officers who will lead our Association in the coming year.

President



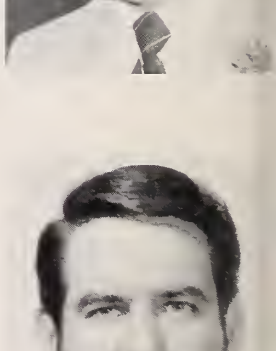
Earnest C. Atkins, M.D., our new MAG president, is a native of Marietta. Dr. Atkins earned his M.D. degree from Emory University School of Medicine and has practiced general surgery in Decatur since 1959. He is a clinical assistant professor in surgery at the Emory University School of Medicine. He is past Chief of Staff at DeKalb General Hospital and currently president of the medical staff of Decatur Hospital and a member of its Board. Some of the positions this longtime physician leader has held include Diplomate of the American Board of Surgeons and the Pan American Medical Society; Fellow of the American College of Surgeons and the Southeastern Surgical Conference; past-president of the J. C. Thoroughman Surgical Society, the DeKalb Medical Society, and the Georgia Medical Care Foundation; and secretary and president-elect of the MAG. Better patient care at a reasonable cost is his top priority.

President-Elect

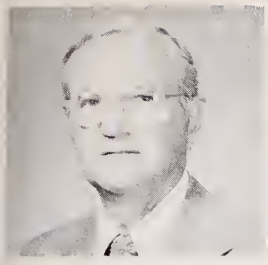


H. Hilt Hammett Jr., M.D., has served the MAG in the past as second vice president, first vice president, a member of the Board of Directors, and alternate delegate to the AMA. A graduate of Emory University School of Medicine, Dr. Hammett has practiced in LaGrange since 1949. He is a specialist in ophthalmology and otorhinolaryngology. Professionally he is a Fellow of the American College of Surgeons; a Diplomate of the American Board of Otorhinolaryngology and the American Academy of Ophthalmology and Otorhinolaryngology; a former Chief of Staff and current staff member of the West Georgia Medical Center; a past-president of Troup County Medical Society; Chairman of the Board of Directors of Blue Shield of Georgia/Columbus, Inc.; and a member of numerous medical and specialty societies. He is also an active member of the First Presbyterian Church of LaGrange.

First Vice President



Richard A. Griffin III, M.D., F.A.C.S., is a general surgeon practicing in Cartersville. Born in Dahlonega, he received his M.D. degree from the Medical College of Georgia. A past president of the Bartow County Medical Society, he is serving his fourth term as a delegate from that county to the House of Delegates. Dr. Griffin is a past president of the Seventh District Medical Society and currently its director, the medical director and a board member of the Georgia Medical Care Foundation, and a board member of the Appalachian Georgia Health Systems Agency.



Second Vice President

S. William Clark Jr., M.D., is an ophthalmologist practicing in Waycross. He received his M.D. degree at Emory University School of Medicine and trained at Grady Hospital in Atlanta. Dr. Clark is a past president of the Ware County Medical Society, the Eighth District Medical Society, and the Georgia Society of Ophthalmology and Otolaryngology; a Delegate to the American Association of Ophthalmology; a Fellow of the American Academy of Ophthalmology and Council Member of the Georgia Society of Ophthalmology.



Secretary

William D. Logan Jr., M.D., is a thoracic and cardiovascular surgeon in Atlanta, where he received his M.D. degree from Emory University School of Medicine. Dr. Logan is a past president of the Medical Association of Atlanta and the Atlanta Lung Association. He is on the Board of Governors of the Georgia Chapter, American College of Chest Physicians. He is vice president of the Southern Thoracic Surgeons Association and president of the medical staff at Georgia Baptist Medical Center.



Treasurer

James H. Sullivan, M.D., a Columbus urologist, received his M.D. degree from the Medical College of Georgia and is also a graduate pharmacist. He is a member of the American Board of Urology and serves on the Board of Directors and Executive Committee of three hospitals in Columbus. Dr. Sullivan is a past president of the Muscogee County Medical Society and has served MAG as first vice president and second vice president. This is his third year as treasurer.

1979-80 ROSTER

One free copy of the 1979 Roster will be mailed to each active member of the Medical Association with the August 1979 issue of the *Journal.*

This valuable publication lists: MAG officers; committees of the Association and their membership; Auxiliary officers and their addresses; district, county medical society and specialty society officers; MAG members and their addresses, both in alphabetical order and by county medical society.

Additional copies of the roster for use at home or in a second office will be available to members by advanced order for $5 a copy. Checks should be made payable to the Medical Association of Georgia. Copies that have been ordered in advance will be mailed out at the end of August.

the association
the association
the association

NEW MEMBERS

Hobson, Gerald J., Cobb—N1—OPH
653 Cherokee St., Marietta 30060

Humphries, Charlie Jr., Dougherty—ACT—OBG
401-B South Madison St., Albany 31701

Krissman, Paul H., Cobb—I&R—IM
754 Cherokee St., Marietta 30060

May, William E., Bibb—N1—IM
380 Hospital Dr., Ste. 460, Macon 31201

McDaniel, F. Ellen, Richmond—I&R—DR
Dept. of Radiology, Talmadge Hospital, Augusta 30901

McGugan, Arthur D., GA Med. Soc.—ACT—D
46 Medical Arts, Savannah 31405

Nagendra, A. K., Baldwin—ACT—U
P.O. Box 1308, Milledgeville 31061

Pomerance, Alan J., DeKalb—N1—OBG
365 Winn Way, Ste. 351, Decatur 30030

Raila, Frank Arthur, Laurens—S—R
VA Medical Center, Dublin 31021

Roth, Michael, Richmond—ACT—OPH
Dept. of Ophthalmology, Medical College of Georgia, Augusta 30909

Simmons, Bernard Russell, Muscogee—ACT—U
1021 Talbotten Rd., Columbus 31904

Underwood, C. Richard, Muscogee—I&R—US
P.O. Box 951, Columbus 31902

Yarrington, Ronald M., Colquitt—I&R—GS
717 S. Main St., Moultrie 31768

PERSONALS

First District

Frank D. Glenn, M.D., a Statesboro urologist, has recently been certified by the American Board of Urology, Inc.

Third District

William E. Adams, M.D., Columbus, has been named a Diplomate of the American Board of Neurological Surgery.

Garry L. August, M.D., Columbus, has recently returned from Bethesda, Maryland, where he attended a week-long seminar on endocrinology held at the National Institute of Health.

Columbus physicians, **Harry H. Brill, M.D.,** and **Gordon C. Miller, M.D.,** have been recertified as Diplomates of the American Board of Internal Medicine.

Norman I. Goldman, M.D., from Columbus, was inducted as a Fellow of the American College of Physicians in San Francisco.

William Taylor, M.D., Columbus, attended the AMA Leadership Seminar for Hospital Medical Staff Leaders in Las Vegas, Nevada, held May 11-13.

Fifth District

Douglas Skelton, M.D., commissioner of the Georgia Department of Human Resources in Atlanta, was the featured luncheon speaker at a national symposium on psychiatric-mental health nursing held at the Hyatt Regency Atlanta Hotel May 14.

Sixth District

Joseph A. Blissit, M.D., a McDonough family practitioner, was recently appointed Chief of Staff at the Henry County General Hospital.

Johnny Deen, M.D., a Thomaston ophthalmologist, was host to two Russian visitors, Dr. Fyodorov Svyatoslav, chief professor and doctor of medical science of the Moscow Scientific-Research Laboratory of Experimental and Clinical Problems of Eye Surgery, and Boris Gustarev, Director of Medinstrument.

Macon physician, **Hugh F. Smission Jr., M.D.,** was installed as President of the Georgia Neurosurgical Society during their annual meeting at Hilton Head Island in late March.

Jack Whitworth, M.D., of West Point, Georgia, retired June 4 as the medical director of West Point Pepperell Manufacturing Co.

Ninth District

On May 3, **Margarita Guzman, M.D.,** opened an office in Dahlonega for the practice of general surgery.

Tenth District

Joseph M. Echols, M.D., Augusta, has been elected to the Board of Directors of the Citizens and Southern National Bank.

J. Graham Smith, M.D., chairman of the Department of Dermatology at the Medical College of Georgia, has been elected president of the Society for Investigative Dermatology.

SOCIETIES

Mort Enright, Director of the Speakers Training Program for the American Medical Association was in Columbus Saturday, May 12, to conduct a Speakers Training Program for the **Muscogee County Medical Society.** These seminars are designed to teach the physicians to tell medicine's story.

David Rosenthal, M.D., a member of the Surgical Specialists of Atlanta, P.C., spoke to the **Upson County Medical Society** (Thomaston) on May 14. His topic was the diagnosis and treatment of arterial insufficiency of the lower extremities and carotid arteries.

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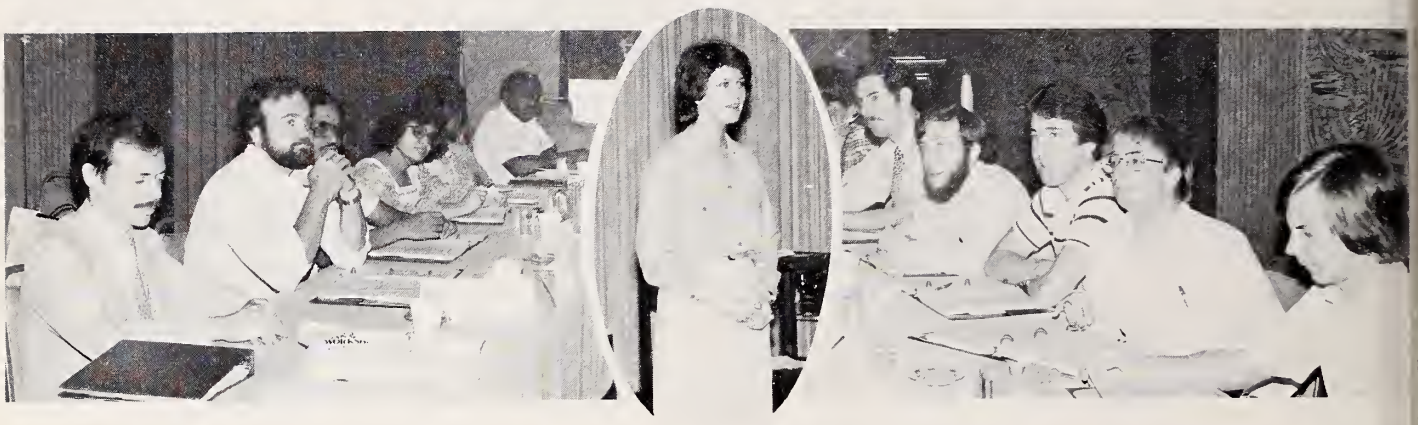
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Lynn Dowling, AMA Representative from Chicago, instructs young physicians starting their practices. From left, Byron Perry, Atlanta; John Drummond, Decatur; Subramanyam Naidu, Atlanta; Gulzar Kassam, Doraville; Victoria Musey, Decatur; John Harper, Conley; Richard Laubaugh, Columbus; and Dale Morris, Milan Schmidt, Bill Hammond, D. J. Underwood, all from Macon.

Practice Management Workshops Serve Young Physicians

The practice management workshops for young physicians starting their practices were so popular this year that the Medical Association of Georgia (MAG) had to schedule a third one to accommodate the overflow from the first two. A total of 75 physicians, mostly second- and third-year residents, attended the 2-day workshops in Atlanta in January, March, and May. Enrollment has grown each year from the first workshop in 1974, which had 15 participants.

This year well-qualified faculty from the AMA's Department of Practice Management guided the workshop participants through the thickets of such areas as office site selection, hiring and firing personnel, appointment scheduling, medical records, telephone management, insurance, and accounts receivable. In addition, attorneys spoke on corporate law and legal aspects of the doctor-patient relationship. These subjects, all important to the success of a medical practice, are seldom covered in medical school or residency training.

It is interesting to observe each year where the workshop participants come from and where they plan to establish their practices. This year most (61) were from Georgia, with 32 doing their residencies in Atlanta, 11 in Augusta, eight in Columbus, five in Macon, and two in Savannah. Other participants came from programs in North Carolina, Alabama, Florida, Tennessee, South Carolina, Virginia, New Jersey, and Connecticut. Many of the residents had not yet selected a location for establishing their practices, but choices ranged from Atlanta (11) to north Georgia (2); south Georgia (8); Sparta, Winchester, and Kingsport, Tennessee; Montgomery and Mobile; Pensacola and Tallahassee; and as far distant as Bonham, Texas; Lexington, Massachusetts; and Alexandria, Egypt.

As in past years, the specialties most represented at the workshop were internal medicine (31) and family practice (22). Others were obstetrics/gynecology, otolaryngology, gastroenterology, orthopedics, pediatrics, ophthalmology, plastic surgery, and psychiatry.

The MAG broke new ground this year by offering a 1-day workshop for medical office managers. It was held a day prior to one of the resident workshops, and the same AMA faculty was present. The good attendance would seem to indicate that there is a demand for this kind of education in our state.

(Report prepared by Stephen Daniel, Ph.D., Assistant Executive Director – Education.)

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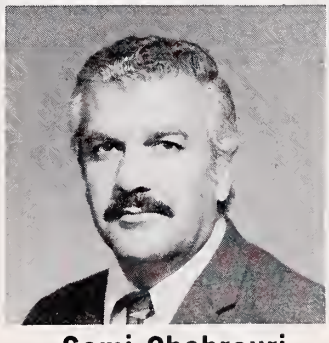
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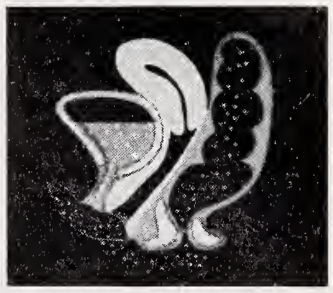
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Indications and Usage: For the treatment of urinary tract infections due to susceptible strains of the following organisms: *Escherichia coli, Klebsiella-Enterobacter, Proteus mirabilis, Proteus vulgaris, Proteus morganii.* **It is recommended that initial episodes of uncomplicated urinary tract infections be treated with a single effective antibacterial agent rather than the combination.** *Note:* The increasing frequency of resistant organisms limits the usefulness of all antibacterials, especially in these urinary tract infections.

Also for the treatment of documented *Pneumocystis carinii* pneumonitis. To date, this drug has been tested only in patients 9 months to 16 years of age who were immunosuppressed by cancer therapy.

The recommended quantitative disc susceptibility method (*Federal Register,* 37:20527-20529, 1972) may be used to estimate bacterial susceptibility to Bactrim. A laboratory report of "Susceptible to trimethoprim-sulfamethoxazole" indicates an infection likely to respond to Bactrim therapy. If infection is confined to the urine, "Intermediate susceptibility" also indicates a likely response. "Resistant" indicates that response is unlikely.

Contraindications: Hypersensitivity to trimethoprim or sulfonamides; pregnancy; nursing mothers; infants less than two months of age.

Warnings: Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been associated with sulfonamides. Experience with trimethoprim is much more limited but occasional interference with hematopoiesis has been reported as well as an increased incidence of thrombopenia with purpura in elderly patients on certain diuretics, primarily thiazides. Sore throat, fever, pallor, purpura or jaundice may be early signs of serious blood disorders. Frequent CBC's are recommended; therapy should be discontinued if a significantly reduced count of any formed blood element is noted.

Precautions: Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, severe allergy or bronchial asthma. In patients with glucose-6-phosphate dehydrogenase deficiency, hemolysis, frequently dose-related, may occur. During therapy, maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function.

Adverse Reactions: All major reactions to sulfonamides and trimethoprim are included, even if not reported with Bactrim. *Blood dyscrasias:* Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia. *Allergic reactions:* Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis. *Gastrointestinal reactions:* Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, diarrhea and pancreatitis. *CNS reactions:* Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness. *Miscellaneous reactions:* Drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L. E. phenomenon. Due to certain chemical similarities to some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia in patients; cross-sensitivity with these agents may exist. In rats, long-term therapy with sulfonamides has produced thyroid malignancies.

Dosage: Not recommended for infants less than two months of age.

Urinary Tract Infections: Usual adult dosage—1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 10-14 days.

Recommended dosage for children—8 mg/kg trimethoprim and 40 mg/kg sulfamethoxazole per 24 hours, in two divided doses for 10 days. A guide follows:

Children two months of age or older:

Weight		Dose—every 12 hours	
lbs	kgs	Teaspoonfuls	Tablets
20	9	1 teasp. (5 ml)	½ tablet
40	18	2 teasp. (10 ml)	1 tablet
60	27	3 teasp. (15 ml)	1½ tablets
80	36	4 teasp. (20 ml)	2 tablets or 1 DS tablet

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Below 15	Use not recommended

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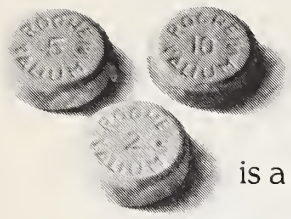


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The effectiveness of Valium (diazepam/Roche) in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

Usage in Pregnancy: **Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

Dosage: Individualize for maximum beneficial effect. *Adults:* Tension, anxiety and psychoneurotic states, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. *Geriatric or debilitated patients:* 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) *Children:* 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

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THE COVER

Richard Lyons of TFC has beautifully depicted the subject of the editorial on p. 742: the bee, wasp, hornet, and yellow jacket. Dr. Betty Wray's article discusses how to manage hypersensitive reactions to such stingers.

Letters to the Editor . . .

Teenage Pregnancy and Called-in Prescriptions — Readers Respond Again

Dear Sir:

After reading the four articles on teenage pregnancy in the May issue of the *Journal of the Medical Association of Georgia*, it is evident that no good thing comes out of teenage sexual intimacy. As one article summarizes, "sex is repeatedly used and abused . . . throughout the land" and ". . . the sexual scene in America is very chaotic and frightening. . . ." These words reflect the confusion and misery of not only the young but our adult world too. Our new, free sexual revolution is not so new and not so free! As the makers and partakers of this polluted sexual atmosphere, we must ask ourselves two questions: one, why have sex education and agencies failed to reduce the grim by-products of teenage sexual activity? and two, would we regard teenage sexual activity as a problem, if there were no out-of-wedlock infants and no venereal disease? (Some people seem to talk this way.)

Dr. Woody's editorial defines the root of the problem and places the responsibility for the solution where it belongs. The issue is a moral and spiritual one, and the solution comes only as parents, teachers, physicians, and all such authority figures teach the moral and spiritual values necessary to bring order and beauty to the sexual areas of our lives.

What in fact has happened and is still happening can be seen if we carry Dr. Woody's analogy of the young person with the gun in the park and no moral-spiritual knowledge a little further. We, the adult community, are standing in the park with ambulances, oxygen, plasma, and tourniquets in the same way that we are standing by our sexually active teenagers with saline solutions, incubators, welfare applications, and venereal disease treatment.

Dr. Woody's statement, "We fail in our responsibility as parents and physicians if we do not set moral standards and instead hand out contraceptives . . ." is, as he states *unpopular* and "not in line with the times"; however, it is *true*. Further, his recognition that teaching these truths is only possible by example, i.e., living them while verbalizing them, is an even more unpopular truth and requires parents and physicians to take a stand as "square" (translated: unsophisticated and uneducated) in their own peer group. Is there no stand because we ourselves have no belief in moral absolutes and therefore certainly have no way of defining moral and ethical values for our children?

Make no mistake, there are two rival world views competing here — the theistic, Judeo-Christian one with moral and ethical absolutes and the atheistic, humanistic one where morals are relative and ethics situational. The latter philosophy has pervaded films, lectures, and booklets given in sex education courses today. Our children are told there are no right or wrong answers, to examine the facts and their own feelings, and to act accordingly. Some of us who believe this is untrue must speak out. We must teach, by precept and example, that teenage sexual intimacy is wrong and let the facts of venereal disease, out-of-wedlock pregnancy with its educational, social, and economic losses, infant and maternal mortality, abortion and its emotional trauma support our position pragmatically.

Sincerely,
Joanne Mason
Atlanta

Dear Sirs:

In reference to the editorial of the May issue of the *JMAG*, it is most refreshing to know that our society does have Christian physicians.

Our present society has forgotten the absolutes of life. Our children are not taught the moral values of life, and in our office practice we have forgotten to express views to patients, especially our young patients, and sometimes it takes only this expression of the values of life to plant the seed in a young mind which might turn their moral values upward.

We need more editorials and more articles with this trend of thought, and I would encourage every effort to upgrade the morals of our young population.

Sincerely,
Peter Hydrick, M.D.
East Point

Dear Sir:

I was so very thankful to read your refreshing viewpoint in "Another Look at Teen-Age Pregnancy" in the May issue of the *Journal of the MAG*. In reading other doctors' viewpoints, I am disappointed and appalled to see the word "choice" used in connection with premarital sex. As a nurse, physician's wife, mother of four, and a college student during the '60's new morality, I know that viewpoint is poison to any life.

Why would any thinking man or woman — particularly a professional person whose occupation has always been considered one of integrity — even consider giving young people a choice of which contraceptive to use when they are not married! It seems that the "blind are leading the blind" when such a choice is offered, and they will both surely fall with such ill advice. They discuss the value of postponing pregnancy for the sake of society, to get an education so that there will be fewer on welfare; but do they let young persons know that pre- or extra-marital sex is a sin and that sin damages our lives. Thank God there is hope in His merciful plan of salvation where every person can find forgiveness by trusting in the only Perfect One

alive — our Lord Jesus Christ. My heart really goes out to every person who is searching for answers in life. If only these physicians will give them real, workable, honest answers for a truly satisfying life, then medicine as a profession could meet one of society's most pressing needs. Sex has a wonderful place in our lives, but without love (really caring about another's needs), it is so harmful, abusive, and unfulfilling.

The only good programs of sex education would be those which teach the beauty and wonder of reproduction on a factual basis. Period! But if there is a tendency to teach young people what to *do* with those facts, then it must be according to the absolute standards set by the unchanging, all-wise God of our Judeo-Christian culture. Otherwise, where do these physicians think they are receiving wisdom to teach young people? The teen-agers themselves, having experienced pre-marital sex, can tell the story "like it is."

Teen-age pregnancies, venereal disease, birth defects, etc. will continue to plague the medical profession until they are willing to use the wisdom of God's Word as their plumb-line. Isn't it amazing that as late as the mid-1800's, the medical profession had not proclaimed a method of sanitation to prevent disease and spread of infections even though several thousand years earlier God gave Moses specific directions for washing hands and changing clothes for the purpose of good health?

I am thankful for all physicians, like you, who are willing to recognize and care for the physical, mental, and spiritual needs of their individual patients rather than just the materialistic needs of our society. Thank you again for your clear perspective on this grave issue of teen-age pregnancy.

Respectfully yours,
Mrs. Lee T. (Betsy) Allen
Stone Mountain

Dear Sir:

I just read Mr. Berg's article on having office help call in prescriptions. His conclusion is that it appears to be prohibited because it is not expressly authorized by the State.

This kind of thinking is appalling! The State laws do not expressly authorize defecation by doctors either. Does this mean each time we defecate we are breaking the law?

Ours is supposedly a free society. We can do what is not prohibited by law, not we can do only what is spelled out by the law.

Gilbert Goldman
Atlanta




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MEDICAL MEETING CALENDAR

AUGUST

25—*Atlanta;* **POSITIVE APPROACHES TO COST AWARENESS;** contact: Joyce Butler, MAG, 938 Peachtree St., N.E., Atlanta 30309. PH: 404/876-7535.

27-31—*Nashville, TN;* **TEMPORAL BONE SURGICAL DISSECTION;** Category 1 credit; Contact: Education Auditory Research Foundation, 2000 Church St., Nashville, TN 37236.

SEPTEMBER

9-14—*Johnson City, TN;* **SUBSTANCE ABUSE IN YOUTH: PREVENTION AND TREATMENT;** Contact: Dr. Charles F. Johnson, Dept. of Continuing Medical Education, East Tennessee State University College of Medicine, Johnson City, TN 37601. PH: 615/929-5364.

11-12—*Chattanooga, TN;* **TENNESSEE VALLEY MEDICAL ASSEMBLY;** Contact: Chattanooga/Hamilton County Medical Society, 960 E. Third St., Chattanooga, TN 37403.

14-15—*Nashville, TN;* **BLOOD BANKING SYMPOSIUM;** Contact: Vanderbilt Continuing Education, 305 Medical Arts Bldg., Nashville, TN 37212. PH: 615/322-2716.

14-16—*Hilton Head, SC;* **ANNUAL MEETING, GEORGIA GASTROENTEROLOGIC SOCIETY;** Contact: Harold Asher, M.D., 340 Boulevard, N.E., Atlanta 30312. PH: 404/688-6192.

16-21—*Atlanta;* **30TH ANNUAL SESSION, AMERICAN ASSOCIATION FOR LABORATORY ANIMAL SCIENCE;** Contact: Joseph J. Garvey, AALAS, 2317 W. Jefferson St., Ste. 208, Joliet, IL 60435.

19-21—*Atlanta;* **33RD ANNUAL MEETING, AMERICAN ELECTROENCEPHALOGRAPHIC SOCIETY;** Contact: Margaret H. Henry, 38238 Glenn Ave., Willoughby, OH 44094. PH: 212/942-9267.

20-22—*Sea Island;* **ANNUAL MEETING, GEORGIA SURGICAL SOCIETY;** Contact: W. Cecil McGarity, M.D., 1365 Clifton Rd., N.E., Atlanta 30322.

27-28—*Chattanooga, TN;* **SEXUAL DYSFUNCTIONS;** Contact: Dennis K. Wentz, M.D., UT Center for the Health Sciences, 62 S. Dunlap St., Memphis, TN 38163. PH: 901/528-5606.

27-29—*Knoxville, TN;* **ARTHRITIS SYMPOSIUM;** contact: Dennis K. Wentz, M.D., UT Center for the Health Sciences, 62 S. Dunlap St., Memphis, TN 38163. PH: 901/528-5606.

28-29—*Augusta;* **EXTERNAL OCULAR DISEASES;** Category 1 credit; Contact: Dr. Gerald T. Chambers, Division of Continuing Education, Medical College of Georgia, Augusta 30912. PH: 404/828-3967.

28-30—*Callaway Gardens;* **31ST ANNUAL MEETING, GEORGIA HEART ASSOCIATION;** Contact: Georgia Heart Assoc., 2581 Piedmont Rd., N.E., Atlanta 30324.

29—*Chattanooga, TN;* **CURRENT CONCEPTS: DIAGNOSIS AND TREATMENT OF CANCER;** Contact: Dennis K. Wentz, M.D., UT Center for the Health Sciences, 62 S. Dunlap St., Memphis, TN 38163. PH: 901/528-5606.

OCTOBER

2-4—*Augusta;* **BASIC EKG FOR FAMILY PHYSICIANS;** Category 1 credit; Contact: Dr. Gerald T. Chambers, Division of Continuing Education, Medical College of Georgia, Augusta 30912. PH: 404/828-3967.

2-4—*Atlanta;* **AMERICAN COLLEGE OF EMERGENCY PHYSICIANS SCIENTIFIC ASSEMBLY;** Contact: William H. Just, ACEP, 3900 Capital City Blvd., Lansing, MI 48906. PH: 517/321-7911.

5—*Atlanta;* **ADVANCES IN COLON AND RECTAL CANCER — PROGRESS 1979;** Contact: Dept. of Graduate and CME, Ga. Baptist Medical Center, 300 Boulevard, N.E., Atlanta 30312. PH: 404/659-4211, Ext. 2346.

4-6—*Knoxville, TN;* **REGIONAL MEETING, AMERICAN COLLEGE OF PHYSICIANS AND TENNESSEE SOCIETY OF INTERNAL MEDICINE;** Contact: Dennis K. Wentz, M.D., UT Center for the Health Sciences, 62 S. Dunlap St., Memphis, TN 38163. PH: 901/528-5606.

4-6—*Charleston, SC;* **MEETING, ASSOCIATION OF AMERICAN PHYSICIANS AND SURGEONS;** Contact: Elsie Doering, 2625 Butterfield Rd., Ste. 137-S, Oak Brook, IL 60521. PH: 312/325-7911.

8-9—*Johnson City, TN;* **GERIATRICS II: SEX AND THE AGED;** Contact: Dr. Charles F. Johnson, Dept. of Continuing Medical Education, East Tennessee State University College of Medicine, Johnson City, TN 37601. PH: 615/929-5364.

8-11—*Atlanta;* **ANNUAL MEETING, AMERICAN ACADEMY OF FAMILY PHYSICIANS;** Contact: R. Tusken, AAFP, 1740 W. 92nd St., Kansas City, MO 64114.

11-13—*Charleston, SC;* **ANNUAL MEETING, SOUTHEASTERN ALLERGY ASSOCIATION;** Contact: G. Frederick Hieber, M.D., 1401 Monticello Blvd., North, St. Petersburg, FL. PH: 813/525-0861.

11-13—*Knoxville, TN;* **FIRST ANNUAL RADIOLOGICAL CONFERENCE:** Contact: Dennis K. Wentz, M.D., UT Center for the Health Sciences, 62 S. Dunlap St., Memphis, TN 38163. PH: 901/528-5606.

19-21—*Atlanta;* **PSYCHOANALYSIS AND PSYCHOTHERAPY: SIMILARITIES AND DIFFERENCES;** Category 1 credit; Contact: Ralph Roughton, M.D., P.O. Box 122, Colony Square, Atlanta 30361. PH: 404/892-7561.

20-21—*Atlanta;* **MAGNET CONFERENCE;** Category 1 credit; Contact: Ken Williams, MAG, 938 Peachtree St., N.E., Atlanta 30309. PH: 404/876-7535.

27-28—*Nashville, TN;* **AMA REGIONAL CME MEETING: CARDIAC ARRHYTHMIAS; PULMONARY FUNCTION AND BLOOD GASES; ACID-BASE, FLUID, AND ELECTROLYTE BALANCE; BASIC CPR; INFECTIOUS DISEASES; OFFICE ORTHOPEDICS; ADVANCED CPR;** Category 1 credit; Contact: Council on Continuing Physician Education, AMA, 535 N. Dearborn St., Chicago, IL 60610. PH: 312/751-6000.

27-28—*Callaway Gardens;* **PHYSICIAN PLACEMENT SEMINAR;** Contact: Joyce Butler, MAG, 938 Peachtree St., N.E., Atlanta 30309. PH: 404/876-7535.

NOVEMBER

3-4—*Asheville, NC;* **AMA REGIONAL CME MEETING: ELECTROCARDIOGRAPHY; DIABETES; OFFICE DERMATOLOGY; PULMONARY FUNCTION AND BLOOD GASES; PRACTICE MANAGEMENT; CARDIOVASCULAR DISEASE; CHEST X-RAYS; ANTIBIOTICS; ACID-BASE, FLUID, AND ELECTROLYTE BALANCE;** Category 1 credit; Contact: Council on Continuing Physician Education, AMA, 535 N. Dearborn St., Chicago, IL 60610. PH: 312/751-6000.

For additional information on these and other meetings, contact MAG, Division of Education 404/876-7535.

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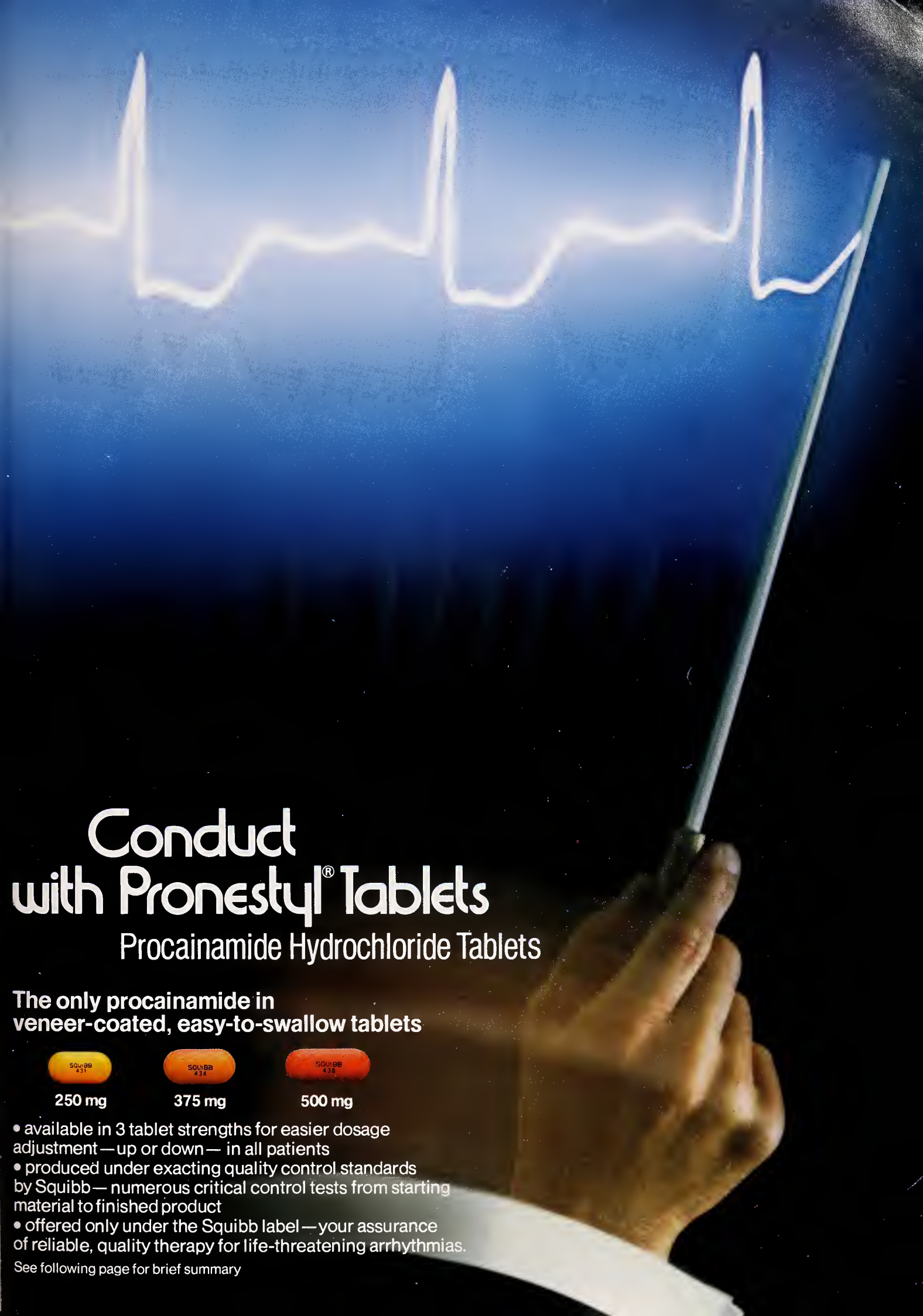
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DESCRIPTION: Pronestyl (Procainamide Hydrochloride) is the amide analogue of procaine hydrochloride and is available for oral administration as veneer-coated tablets providing 250 mg, 375 mg, and 500 mg procainamide hydrochloride.

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PRECAUTIONS: Evidence of untoward myocardial responses should be carefully watched for in all patients. In the presence of myocardial damage with atrial fibrillation or flutter, the ventricular rate may increase suddenly as the atrial rate is slowed; adequate digitalization reduces but does not abolish this danger. Ventricular tachysystole is particularly hazardous if myocardial damage exists.

The dislodgment of mural thrombi producing an embolic episode may occur in correcting atrial fibrillation due to the forceful contractions of the atrium.

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Bear in mind when treating ventricular arrhythmias in patients with severe organic heart disease and ventricular tachycardia that complete heart block, which may be difficult to diagnose, may be present. Since asystole may result if the ventricular rate is significantly slowed without attainment of regular atrioventricular conduction, procainamide should be stopped and the patient re-evaluated.

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A syndrome resembling lupus erythematosus has been reported with oral maintenance procainamide therapy. Common symptoms are polyarthralgia, arthritis and pleuritic pain. Fever, myalgia, skin lesions, pleural effusion and pericarditis may also occur. Rare cases of thrombocytopenia or Coombs-positive hemolytic anemia, possibly related to this syndrome, have been reported. Measure anti-nuclear antibody titers at regular intervals in patients on procainamide for extended periods of time or in whom symptoms suggestive of lupus-like reaction appear; in event of rising titer (anti-nuclear antibody) or clinical symptoms of LE, assess the benefit/risk ratio related to continued procainamide therapy (see boxed Warning). Steroid therapy may be effective if discontinuation of procainamide does not cause remission of symptoms. If the syndrome develops in a patient with recurrent life-threatening arrhythmias not otherwise controllable, steroid-suppressive therapy may be used concomitantly with procainamide.

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A syndrome resembling lupus erythematosus has been reported in patients on oral maintenance therapy (see Precautions). Reactions consisting of fever and chills have been reported, including a case with nausea, vomiting, abdominal pain, acute hepatomegaly, and a rise in serum glutamic oxaloacetic transaminase following single doses of the drug. Agranulocytosis has been occasionally reported following repeated use of the drug, and deaths have occurred. Therefore, routine blood counts are advisable during maintenance procainamide therapy; and the patient should be instructed to report any soreness of the mouth, throat or gums, unexplained fever or any symptoms of upper respiratory tract infection. If any of these symptoms should occur and leukocyte counts indicate cellular depression, procainamide therapy should be discontinued and appropriate treatment should be instituted immediately. Bitter taste, diarrhea, weakness, mental depression, giddiness, psychosis with hallucinations, and hypersensitivity reactions such as angioneurotic edema and maculopapular rash have been reported.

For full prescribing information, consult package insert.

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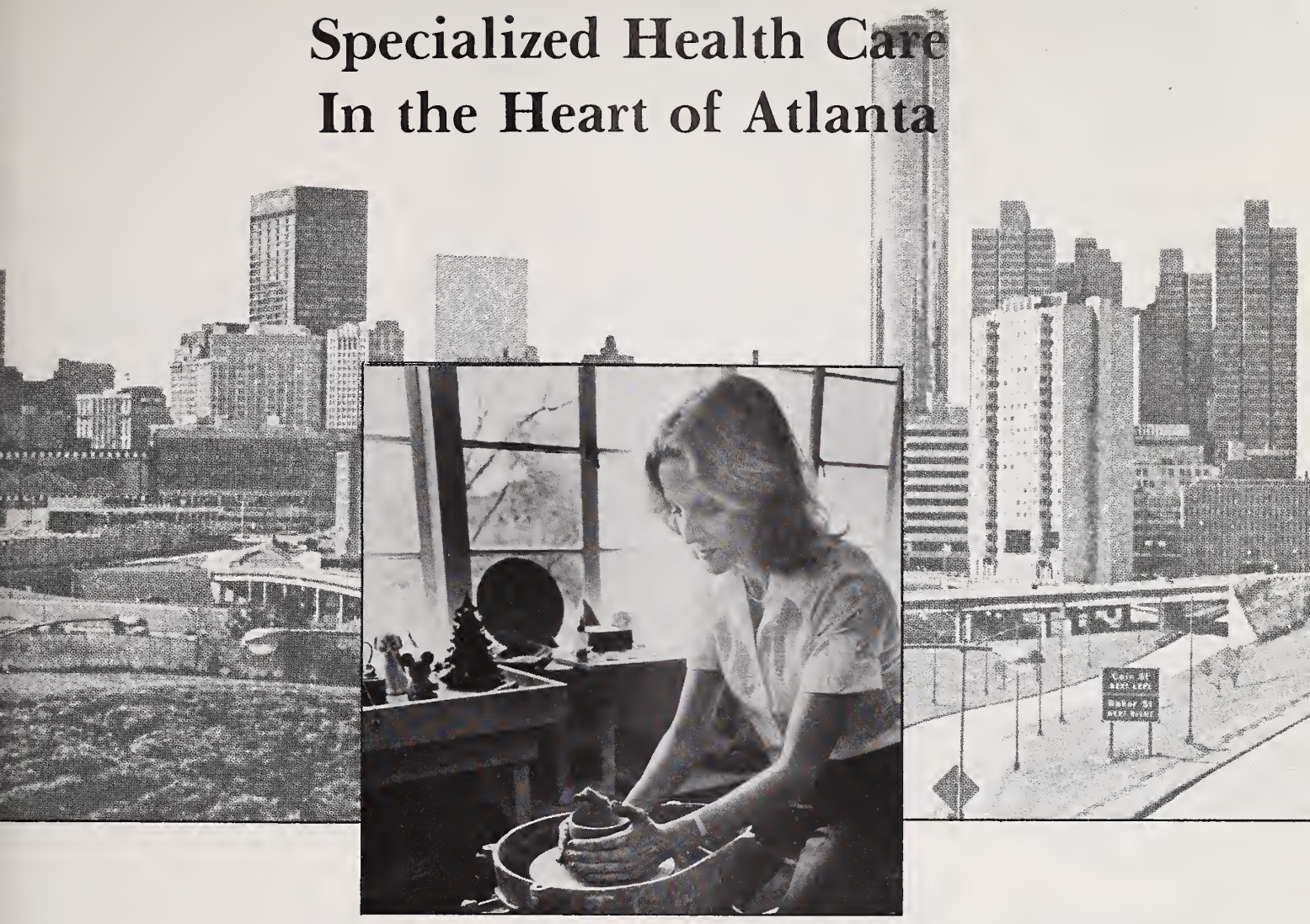
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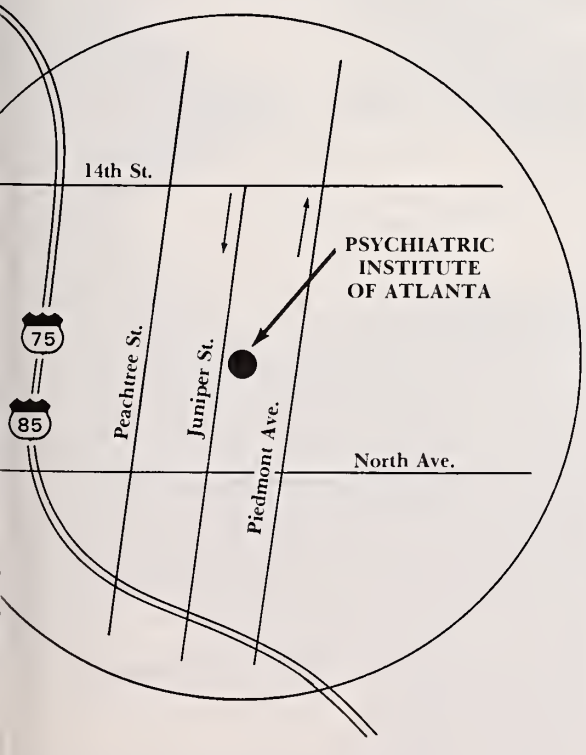
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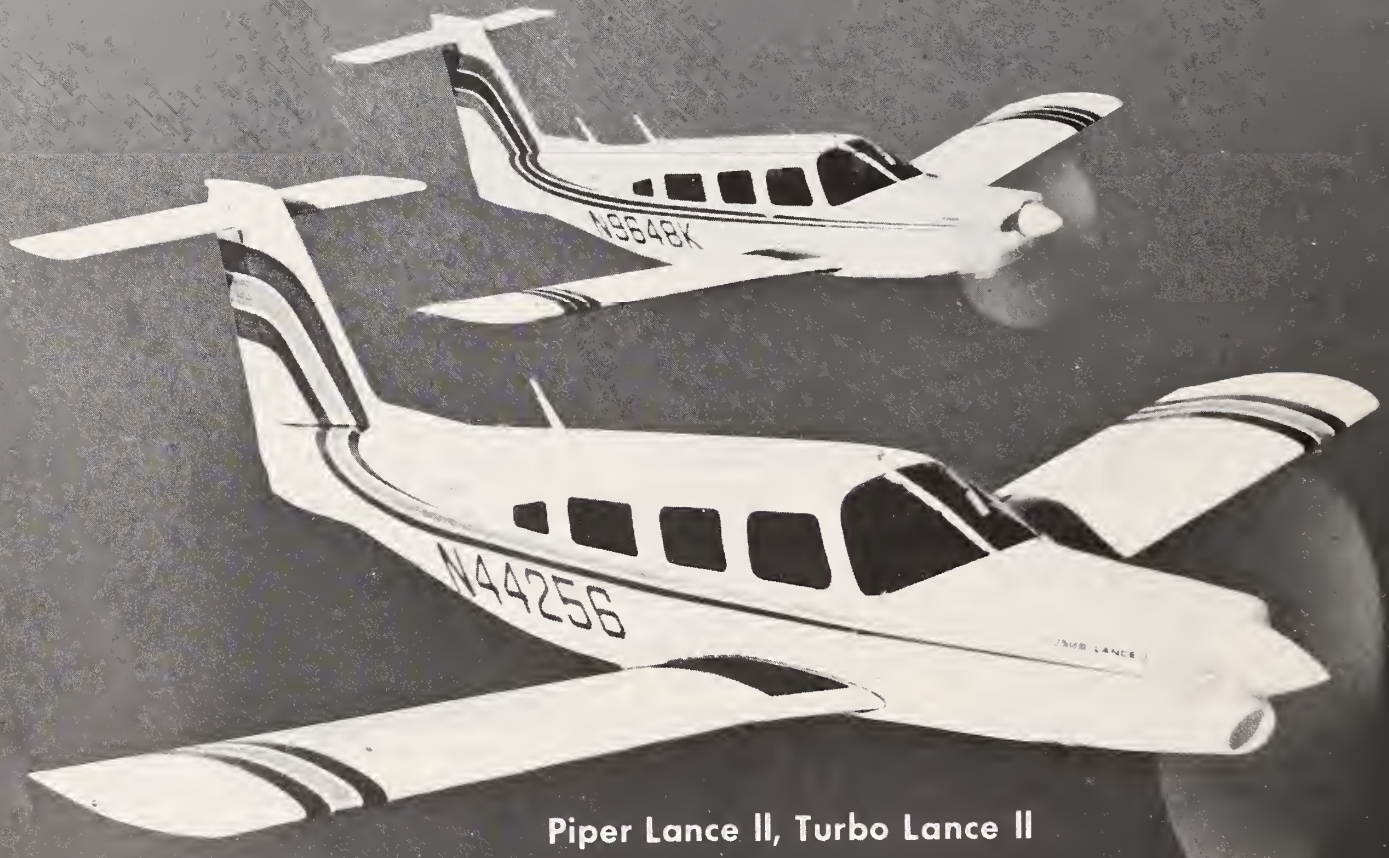
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Cost Containment or Rationing Medical Care—The Role of Government

WILLIAM R. FELTS, M.D., *Atlanta**

I CONGRATULATE the creator of the title of today's program. Its deliberate ambivalence is appropriate. Is cost containment an option to rationing? Or is it synonymous with rationing?

Since my charge is to assert some positions as to my perspective of the proper role of government in addressing objectives relating to the allocation of medical care resources, it is appropriate initially to review a few of the factors that contribute to the matrix of the issues.

Business Week in a September 4, 1978, article asserted: "The unprecedented concern over health in the past 25 years has created the second largest and fastest growing industry in the U.S., employing 6% of the nation's workers, gobbling up nearly 9% of the gross national product, and billing 1,500% more than it did in 1950, while serving only 43% more people. Until very recently the great equation — elaborate health care equals health — held fast, but now the price of that care has become so unhealthy that every segment of the economy, from industry and labor to government and consumer groups is struggling to put a cap on costs."

Separating cost containment from other aspects of concern with medicine and health issues is fraught with difficulties. The greatest source of agitation for recognition of the issue appeared to originate from certain individuals and groups who are recognized advocates for universal national health insurance (NHI). This observation results in reflex resistive reactions from many in organized medicine, and may have caused the issue to be addressed as frequently from political perspectives as from objective, analytic viewpoints. The knowledge that proponents for NHI indicated that a control of costs should precede its enactment do not help dissipate such political aura.

Inflation and the Proposition 13 phenomenon are significant deterrants to precipitous actions by government in the NHI consideration, at least temporarily. But there is no room for complacency. Physicians must also be aware of Measure 4 that surfaced this month [November] as a state referendum in North Dakota. If it had passed, it would have permitted the state health officer to set maximum rates for drugs and any services performed by a doctor, dentist, hospital, nursing home, optician, chiropractor, nurse, or physical therapist. Similar ballot proposals may be spawned elsewhere and intensify congressional pressure for strictly controlled NHI. There is a message that the public is tired of runaway costs, and it is predictable that costs of medical care will be allocated a reasonably high priority for group action.

"It took the federal budget 187 years to reach $100 billion annually (1962); another 9 years to double to $200 billion . . . and 4 years to reach $300 billion."

The American economy also impacts broadly upon all medical/health/social programs. Attempting to control portions of the economy without considering the whole is an exercise in futility. The first priority of government should be to control inflation, and government itself is the greatest culprit in its genesis. It took the federal budget 187 years to reach $100 billion annually (1962); another 9 years to double to $200 billion (1971); another 4 years to reach $300 billion (1975); only 2 more years to top $400 billion (1977); and it is estimated to exceed the $500 billion mark in fiscal 1979. Annual interest on

* Dr. Felts is a past president of the American Society of Internal Medicine. This is a portion of the paper read before the Section on Medicine, Southern Medical Association, 72nd Annual Scientific Assembly, Atlanta, GA, Nov. 11-14, 1978.

the federal debt exceeds $122 million per day. There are 1.1 million more government employees than manufacturing production workers. The number of staff members and legislative aides in the U.S. Congress totals more than 18,000 — double the number of only 10 years ago.

"Annual interest on the federal debt exceeds $122 million per day."

Much of this precipitous growth of government has evolved through the process of the Congress and Executive branches treating difficult problems by a generous prescription of creation of a bureaucracy to address them, sometimes labeled the "top down syndrome." The previously cited figures serve as lurid testimonials to such behavior. And yet bureaucracies are not limited to supervisory federal agencies; sometimes the latter are relatively miniscule when compared with the mandated, metastatic implementing units in state, county, and local governments, and within medical schools, hospitals, clinics — and more recently our offices.

Costs, quality, and technology cannot be addressed realistically without simultaneous consideration of the quantities of services provided. Quantitative considerations provide a simplistic example of the schizophrenic behavior of government with which our responsible medical organizations are having to cope. Congress has sought to stimulate increased quantitative service capability through such approaches as the Hill-Burton program; creation of physician's assistants; increased production of the numbers of physicians by the medical schools; and specific subsidization of certain categorical programs. All of these initiatives have contributed to the cost increases that some in government now seek to control. Secretary Califano recently announced his intent to seek a reduction in the expansion of medical school graduates. Some cynics question how much of the hue and cry from some rural areas about physician shortages results not from actual lack of access to care but from certain bankers and merchants who seek to increase the flow of business traffic in their communities. Can we answer factually the question "how real is the shortage?" I've been told that last month one of the largest organizations representing surgeons was informed it is being investigated by the FTC for restraint of trade because of its announced plan to cooperate with HEW and reduce the number of surgical residencies.

Nonetheless, I believe very strongly that changes stimulated and implemented voluntarily are more likely to be successful and durable than interventions through controls that generally succeed only in stimulating recipients to play the game of "beat the rules." Those opposed to this view sometimes assert that if this is true, Moses would have come down from Mt. Sinai with the Ten Guidelines instead of the Ten Commandments. One could retort that the clarity of intent and language of The Commandments is hardly comparable to the enactments of government.

At a recent meeting, a number of randomized facts were expressed that exemplify much of the data to which the Congress is being exposed:

In one year the HCFA budget jumped from $38 billion to $40 billion for the same services.

Medicare now covers 24 million people over 65, plus the disabled. Of these, those over 74 use ⅓ of the total resources, and by the year 2000 this group will number over 13,000,000 individuals.

Medicaid benefits are skewed among the states with many inter- and intra-state inequities. In a number of states they comprise the largest budget item for the state. Since it is budgetarily uncontrollable it has become a major financial/tax problem for the states and is one of the pressures for state tax increases.

The hospital cost increment for this year for the federal budget exceeds the entire budget of the Assistant Secretary for Health (who retains jurisdiction over the NIH and Public Health Service (PHS) programs).

Vested interests impact continuously upon policy, and one of the major sources of vested interests is the bureaucrats themselves.

Mating of the nation's elderly appears to keep more out of chronic care environments than any government programs yet devised.

Proposals before the 95th Congress would have addressed hospital cost control principally through the devices of limiting capital expenditures and placing caps on hospital revenues. Both approaches are predicated upon the thesis that significant "fat" exists in the system that can be amputated without severe adverse effects. The existence of such "fat" is based chiefly upon circumstantial evidence, with little to indicate its quantity. If it is small the adverse impacts of regulation will be much greater than if it is substantial. At New York's Cornell University, one physician reported that utilization review had discovered only six patient overstays per 9,500 charts reviewed at a projected cost of $34,212 for each patient so identified. But isolated examples of this type are no more valid for firm conclusions than many testimonials cited by Senator Kennedy in his repetitive hearings.

Some of the other strategies in the pipeline of

active consideration by the feds that purport to address the "cost containment" issue include:

- Elective surgery: Campaigns promoting second opinions.
- Technology: Requiring certificates of need for installation in any location, and for replacement.
- Lab services: Tightened administrative procedures and lowered reimbursement through intermediary transmittal letters, plus new legislation.
- Drugs: Federal legislation giving HEW authority over dispensing and distribution.
- Administration of existing insurance programs: Federal Medicare and Medicaid amendments tightening procedures.
- Numerical standards: The guidelines under PL 93-641 established arbitrary numerical goals for the allocation of health services affecting hospital beds and occupancy rates, obstetrical services, neonatal-special care units, pediatric inpatient services, open heart surgery, cardiac catheterization labs, radiation therapy, CAT scanners, and ESRD units. Now Secretary Califano states a commitment to productivity standards, and has asserted that 50% of patient visits for primary care could be handled by nurse practitioners or physician's assistants more economically, yet only 2-5% of such encounters are so managed. (A gratuituous editorial comment could be that the most economical of all, to carry the numerical approach to an extreme, would be the non-visit.) He indicated standards for operating Community Health Centers; for example, that each full-time physician must document at least 4,200 patient encounters per year (averages 81/week) and administrative costs in an ambulatory care clinic should not exceed 20% of total costs. On Oct. 27, 1978, he instructed the National Health Planning Council to begin consideration of the issues raised by employing productivity standards, and announced an intent to heavily involve the newly authorized Center for Health Care Technology to "move swiftly on this problem."
- Physicians fees: Many plans are cited to initiate changes in this area, with negotiated annual fee schedules being the more frequent cliché.

The United States already is witnessing the response from an excellent pharmaceutical industry to similar government intervention by the exodus of much of its research and development, as well as its manufacturing capabilities into countries with less stringent red tape. Not only does America appear to be losing its prestige for leadership, it is losing jobs and resources to other lands. Where and when in the authoritative hierarchy of government will an attempt be made to equate the country's perceived gains with these obvious losses?

But my charge on the program today is to make some projections about what I think a proper role of government should be in this area.

The initial reaction is to assert that it should abandon its positions of intervention, especially in medical care financing, and experiment with the development of alternative incentives within the private sector to assist the poor and the aged. I concede this has no political viability, but it would probably do more to restore medical care costs into relative equilibrium with the remainder of our economy than any other step government can take.

"Cooperative efforts at developing factual and revealing data about medical and health problems are urgently needed. . . ."

A second recommendation is that HEW initiate genuine, cooperative, and constructive efforts with the profession and the public in addressing the issues. This will not be easy and cannot occur rapidly. The bureaucratic-vested-interest approach has seriously damaged credibility and undermined confidence and cannot be undone overnight. Much, if not most, of the governmental and third party data is skewed and of dubious accuracy. Cooperative efforts at developing factual and revealing data about medical and health problems are urgently needed if better bases for decision-making about national policy are to emerge in the future. HEW's adoption on Jan. 1, 1979, of a uniform diagnostic reporting system (ICD-9-CM) for federal programs represents one small step in the right direction, but it will be of incomplete value if a uniform medical procedural reporting system is not similarly initiated. Government could take another important step up the ladder of cooperation by promptly adopting the AMA's *Current Procedural Terminology* for this purpose. In so doing, the government must recognize that functional needs of patients, physicians, and other third parties must be met by such a system, and not just its own. Without addressing the needs of all users no such system can succeed. The objective of accountability justifies good data systems, and predicating their selection process upon politically motivated quid pro quos is inappropriate. Despite propaganda campaigns to the contrary and spotty

examples of fraud and abuse, I believe the multiple functions of the medical care system can withstand a close scrutiny for accountability much better than most of those of government. Many of the current problems we are debating could be more confidently addressed if reliable data existed.

A third recommendation is that the issue of professional decisions, actions, and services provided under the philosophy of ethics — which has been traditional in American medicine — be carefully examined and contrasted with that of deontology, which is the approach in some foreign countries, especially many behind the iron curtain. Actions under the ethical approach of proper conduct, because it is morally correct, contrasts vividly with those of the deontological approach where response is a duty and individual rights are dictated by standards. The latter approach replaces ethic under most governmental systems, and depersonalization of care can result. Although this issue has apparently not concerned many of our political leaders, if indeed they are aware of it, the national consequences of a forced model shift can result in further severe disillusionment of the public and detract from the high quality of the medical profession.

". . . some have estimated that the first year of implementation of an NHI program with benefits similar to . . . Medicare will require at least $40 billion in **new** *taxes."*

A fourth consideration is that government stimulate and, when appropriate, sponsor intensive health care research in the next decade. By this is not meant the traditional bench, basic-science oriented approach (which obviously must be sustained), but an expansion of the nation's cadre of epidemiologists and similar professionals who can objectively scrutinize the effects of medical services and interactions upon the quality of life outcomes as well as upon mortality. Only with more concrete information can reasonable and logical decisions about difficult cost/benefit choices and priorities be made with confidence as to national health policy and resource allocation.

A fifth recommendation is that government seek to stimulate the private insurance industry to develop and offer reasonable policies to the public to cover catastrophic medical events. The definition of catastrophe possibly should be limited to specific categorical medical conditions initially, despite the problems of equity thereby created. Inequities already exist in this regard as exemplified by the End Stage Renal Disease program. Also, a dollar floor should be established for entry that is sufficiently high to assure the program's economic viability for at least 5 to 10 years and to simultaneously serve as an incentive to individuals to secure basic coverage. As a result of the initial limited approach, factual data bases can be derived that will allow more accurate projections of costs that can result from broadening of benefits, as well as allowing an opportunity for better experimentation with incentives. Under such an approach the government undoubtedly will have to subsidize the insurance companies to assure medical catastrophe coverage for the poor and the elderly, the societal groups that remain the chief threats to the fiscal soundness of any medical insurance approach. This also can force a role model choice between medical and social catastrophes.

Recommendation six is that all decision makers within and without government reexamine the logic and consequences of continued automatic application of the "top-down solution" process. Addressing all societal problems by the establishment of hierarchial bureaucracies has resulted in rote behavior and contributed to the expansion of the problem list. It is reminiscent of the adage that "if your only tool is a hammer you tend to view every problem as a nail." Some physician leaders are just as guilty of this approach as our government officials, fostered possibly by academic environments. The identification of incentives to stimulate voluntary approaches to problems by the private sector, although challenging and difficult, is more likely to be successful and durable. Katherine Graham, publisher of the *Washington Post,* concluded a recent talk with the observation, "it's wise for a free society to continue to entrust a lot of judgment to the marketplace, instead of having them preempted by the Congress and the agencies. The challenge is to discipline ourselves, maintain high professional standards, respond to public concerns, and acknowledge occasional mistakes."

My final recommendation, for now, is that the policy of governmental honesty be extended to Americans about all the consequences of an NHI program. Significant quantities of additional desirable services cannot be delivered without greater resources to allocate, and the bottom line of this is increased taxation. For example, some have estimated that the first year of implementation of an NHI program with benefits similar to those of Medicare will require at least $40 billion in **new** taxes.

Another consequence of expanded governmental involvement in cost containment or expanded insurance programs will be the threat of a rationing of medical services. Such rationing has occurred in almost all foreign countries that have initiated extensive NHI programs. Delayed technologic implementation, queuing, and triage are the covert and overt devices by which such rationing occurs. By the

time the rank and file public recognizes what has happened, it is too late to reverse the political process.

Can it be avoided here? I don't know. Inflation must be controlled. Government spending and taxation need to achieve reasonable balance. In the medical sector, physicians and institutions must take a hard look at their procedures and charges and voluntarily seek to assure conscientious, studied, meaningful expenditures. The public must participate in the process, if it is to succeed, in responsibly striving for realistic expectations for outcome of interventions, and for the appropriate utilization of resources. Implicit in this statement is the assumption that restoration of the professional liability problems to a fair and equitable perspective is included. Can our society learn, benefit, and avoid the often tragic results of unfavourable social/medical experimentations implemented by many foreign countries? The examples are there.

If we are to achieve a stable economy, a reasonably balanced government, and maintain some semblance of control over our individual destinies, such efforts to restore a reasonable balance must be made. As professionals, we need to strive for the proper physician perspective and to use our organizations effectively. Of the 220 million Americans, only some 350,000 are doctors, about 0.3%. Our numbers obviously count for little in the voting booths. But as community leaders we have the opportunity, and I believe the responsibility, to participate actively in the processes.

Update on Payment for Routine Hospital Admission Tests

The 1979 House of Delegates of the Medical Association of Georgia (MAG) adopted the recommendation of the Committee on Third Party Relations that the MAG

> "establish a policy recommending to all hospital staffs that all tests performed in hospitals be ordered by physicians except as required by state law."

This action was taken in response to the Medical Necessity Project initiated by Blue Cross and Blue Shield. The National Blue Cross/Blue Shield Plans made the recommendation to withhold payment for routine hospital admission tests which are not specifically ordered by the patient's physician. This policy addresses the practice of standing hospital orders for tests on all admissions without regard to the patient's condition and places the authority for ordering those tests with the individual and not the hospital. MAG has informed all Georgia hospital medical staffs, hospital administrators, the Georgia Hospital Association, and third party payors of its action in this matter.

Medical Association of Georgia — Statement on Continuing Medical Education

All members of the Medical Association of Georgia (MAG) are strongly encouraged to follow the recommendations of their specialty societies and specialty boards on the desirable amount of participation in continuing medical education (CME) activities. Such recommendations are probably better received than those emanating from other sources.

The MAG does not support the concept of CME as a requirement for re-registration of the license to practice medicine. The primary purpose of relicensure should be to assure that the physician is competent to continue rendering quality care, and since there has not yet been convincing proof linking CME to physician competence, it would be premature to mandate CME for relicensure. States with such requirements have encountered considerable problems with enforcement and administration.

There is no CME requirement for membership in the MAG. The physician's best motivation for participating in CME is not coercion but the desire to maintain professional knowledge and ability through education. It would be most difficult to design and administer a system of mandatory CME which gives proper credit to the best ways in which each physician learns.

The MAG strongly supports the development and accreditation of quality CME programs in local hospitals. Although every staff member's participation in hospital CME activities should be documented and reviewed at the time of reappointment, it should be left to the individual hospital to determine whether there should be a CME requirement for staff privileges.

Voluntary achievement in CME is a major priority not only for the MAG's Education Committee but for the entire MAG. To accomplish this, the MAG sets a goal of having 100% of its members qualify for the AMA's Physician's Recognition Award within the next 5 years.

Heart Association's Annual Scientific Sessions Scheduled September 28-30 at Callaway Gardens

The Heart Association's annual Scientific Sessions for Physicians will be presented Friday through Sunday, Sept. 28-30, 1979, at Callaway Gardens.

On Friday morning Ernest Craige, M.D., from the University of North Carolina School of Medicine, will speak on "Echophonocardiography in Assessment of Heart Sounds and Murmurs," and Miltiadis A. Stefadouros, M.D., from the Medical College of Georgia will speak on "Hemodynamic Assessment of Acquired Valvular Heart Disease by Echocardiography and Phonocardiography."

Speaking on Saturday morning will be William P. Castelli, M.D., Framingham Heart Study, on "Infarct Prevention and Lipid Control: How Early Should We Begin?" and "Secondary Prevention in Patients With Diagnosed Ischemic Heart Disease," and James T. Willerson, M.D., from the University of Texas Southwestern Medical School whose topic will be "Limitation of Infarct Size."

On Sunday morning, the physicians will hear Charles A. Sanders, M.D. from Massachusetts General Hospital speak on "Coronary Disease: Medical, Surgical, and Economic Management — Where Are We?," and Herman K. Hellerstein, M.D., from Case Western Reserve University discuss "Comprehensive Rehabilitation." Small group seminars will be presented each morning, featuring guest faculty and Georgia physicians.

Scientific Sessions for Physicians is held in conjunction with the Heart Association's Annual Meeting and Scientific Sessions for Nurses, Dietitians, and Nutritionists. There will also be a General Session for all Heart Association volunteers, including physicians, and new sessions for non-medical volunteers and the general public. A special event of this year's meeting will be a dinner Saturday night in honor of M. Linwood Beck, who retired June 30 after 30½ years as Executive Director of the Heart Association in Georgia.

Technical exhibits of heart-related products and equipment will be an important part of the meeting again this year, with coffee breaks and a social hour Friday night in the Exhibit Hall. Golf, tennis, and bridge tournaments are planned for Saturday afternoon.

Joseph M. Turner, M.D., of Tifton, is the outgoing President of the Heart Association. Mark E. Silverman, M.D., of Atlanta, will be installed as president at the Annual Meeting Luncheon on Friday.

Scientific Sessions are an activity of the Heart Association's physician education committee. Robert B. Copeland, M.D., LaGrange, is immediate past chairman, and Lloyd S. Goodman, M.D., Savannah, is chairman for 1979-80. Arthur J. Merrill Jr., M.D., Atlanta, is the committee member in charge of planning the 1979 sessions.

In addition to rooms at Callaway Gardens Inn, the Heart Association has reserved 90 one-bedroom cottages for families and groups. To register, contact the Heart Association, 2581 Piedmont Road, N.E., Atlanta 30324. August 31 is the postmark deadline for early registration at a reduced rate.

Safety Caps Work

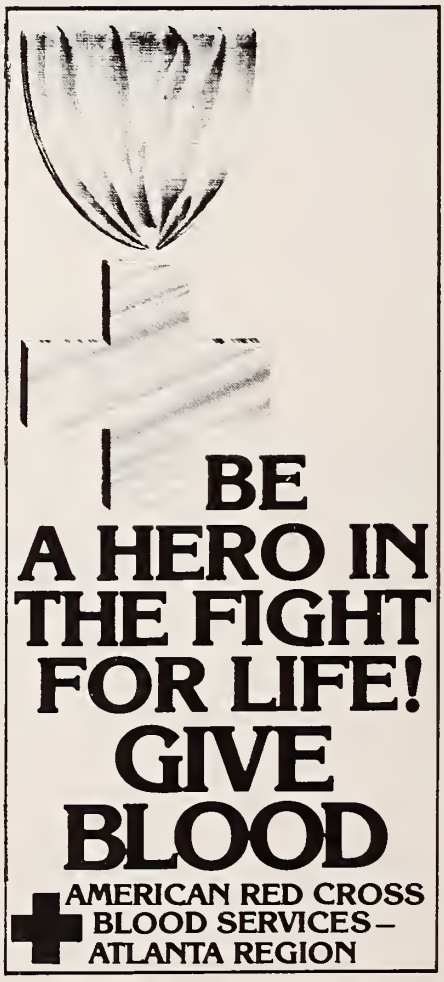
Even adults have been known to become frustrated with "child-proof" aspirin containers, but a new study shows that the safety packaging has cut nearly in half the number of accidental aspirin poisonings among young children.

Researchers from the U.S. Consumer Product Safety Commission estimate that safety packaging has reduced the incidence of accidental ingestion of baby aspirin by 45 to 55%, and of nonbaby aspirin products by 40 to 45%. Data were collected from Poison Control Centers throughout the country and from the National Center for Health Statistics.

According to statistics from the National Safety Council, products containing aspirin cause more deaths to children under 5 years of age than any other type of medication.

In addition to the introduction of safety packaging, the Food and Drug Administration voted in 1966 to limit the number of tablets contained in baby aspirin packages to 36 and to increase warnings on labels.

The researchers expressed the hope that similar safety measures would be considered for other over-the-counter drugs, particularly for those medications with flavoring or other characteristics which make them attractive to children.



When the indications surface...



NEOSPORIN® Ointment

(Polymyxin B-Bacitracin-Neomycin)

Wellcome

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Each gram contains: Aerosporin® (Polymyxin B Sulfate) 5,000 units, bacitracin zinc 400 units, neomycin sulfate 5 mg (equivalent to 3.5 mg neomycin base), special white petrolatum qs; in tubes of 1 oz and 1/2 oz and 1/32 oz (approx.) foil packets.

INDICATIONS: *Therapeutically,* (as an adjunct to systemic therapy when indicated), for topical infections, primary or secondary, due to susceptible organisms, as in: infected burns, skin grafts, surgical incisions, otitis externa; primary pyodermas (impetigo, ecthyma, sycosis vulgaris, paronychia); secondarily infected dermatoses (eczema, herpes, and seborrheic dermatitis); traumatic lesions, inflamed or suppurating as a result of bacterial infection. *Prophylactically,* the ointment may be used to prevent bacterial contamination in burns, skin grafts, incisions, and other clean lesions. For abrasions, minor cuts and wounds accidentally incurred, its use may prevent the development of infection and permit wound healing.

CONTRAINDICATIONS: This product is contraindicated in those individuals who have shown hypersensitivity to any of its components. Do not use in the eyes or in the external ear canal if the eardrum is perforated.

WARNING: Because of the potential hazard of nephrotoxicity and ototoxicity due to neomycin, care should be exercised when using this product in treating extensive burns, trophic ulceration and other extensive conditions where absorption of neomycin is possible. In burns where more than 20 percent of the body surface is affected, especially if the patient has impaired renal function or is receiving other aminoglycoside antibiotics concurrently, not more than one application a day is recommended.

When using neomycin-containing products to control secondary infection in the chronic dermatoses, it should be borne in mind that the skin is more liable to become sensitized to many substances, including neomycin. The manifestation of sensitization to neomycin is usually a low grade reddening with swelling, dry scaling and itching; it may be manifest simply as failure to heal. During long-term use of neomycin-containing products, periodic examination for such signs is advisable and the patient should be told to discontinue the product if they are observed. These symptoms regress quickly on withdrawing the medication. Neomycin-containing applications should be avoided for that patient thereafter.

PRECAUTIONS: As with other antibacterial preparations, prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs.

ADVERSE REACTIONS: Neomycin is a not uncommon cutaneous sensitizer. Articles in the current literature indicate an increase in the prevalence of persons allergic to neomycin. Ototoxicity and nephrotoxicity have been reported (see Warning section).

Complete literature available on request from Professional Services Dept. PML.

Pinworm: simply awful



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Vermox: awfully simple

No dosage calculation

one dose single VERMOX 100 mg tablet is the treatment for pinworm in both adults and children* of all body weights; no dosage calculations or confusion

one time the VERMOX tablet may be taken any time that is convenient, so that normal routines won't be interrupted; convenient schedule encourages compliance

one tablet chewable, orange-flavored VERMOX tablet may also be crushed and mixed or simply swallowed; no messy liquid to spill and no dye to stain

95% cure mean cure rate in clinical studies was 95% (range: 90%-100%) after treatment with one VERMOX tablet; in cases of reinfection, a second tablet is advised

* Because Vermox has not been extensively studied in children under two years of age, the relative benefit/risk should be considered before treating these children. Vermox is contraindicated in pregnancy (see: Pregnancy Precautions) and in persons who have shown hypersensitivity to the drug.

Vermox chewable tablets
TRADEMARK
(mebendazole)

escription VERMOX (mebendazole) is methyl benzoylbenzimidazole-2-carbamate.

tions VERMOX exerts its anthelmintic effect by ocking glucose uptake by the susceptible helminths, ereby depleting the energy level until it becomes adequate for survival.

man, approximately 2% of administered meben- zole is excreted in urine as unchanged drug or a imary metabolite. Following administration of 100 mg mebendazole twice daily for three consecutive days, sma levels of mebendazole and its primary etabolite, the 2-amine, never exceeded 0.03 μ g/ml d 0.09 μ g/ml, respectively.

dications VERMOX is indicated for the treatment of *churis trichiura* (whipworm), *Enterobius vermicularis* nworm), *Ascaris lumbricoides* (roundworm), *Ancylos- na duodenale* (common hookworm), *Necator ameri- nus* (American hookworm) in single or mixed infections. icacy varies in function of such factors as pre-existing diarrhea and gastrointestinal transit time, degree of infection and helminth strains.

Contraindications VERMOX is contraindicated in pregnant women (see: Pregnancy Precautions) and in persons who have shown hypersensitivity to the drug.

Precautions *PREGNANCY:* VERMOX has shown embryotoxic and teratogenic activity in pregnant rats at single oral doses as low as 10 mg/kg. Since VERMOX may have a risk of producing fetal damage if administered during pregnancy, it is contraindicated in pregnant women.

PEDIATRIC USE: The drug has not been extensively studied in children under two years; therefore, in the treatment of children under two years the relative benefit/risk should be considered.

Adverse reactions Transient symptoms of abdominal pain and diarrhea have occurred in cases of massive infection and expulsion of worms.

Dosage and administration The same dosage schedule applies to children and adults. The tablet may be chewed, swallowed or crushed and mixed with food.

For the control of pinworm (enterobiasis), a single tablet is administered orally, one time.

For the control of roundworm (ascariasis), whipworm (trichuriasis), and hookworm infection, one tablet of VERMOX is administered, orally, morning and evening, on three consecutive days.

If the patient is not cured three weeks after treatment, a second course of treatment is advised. No special procedures, such as fasting or purging, are required.

How supplied VERMOX is available as chewable tablets, each containing 100 mg of mebendazole, and is supplied in boxes of twelve tablets.

VERMOX (mebendazole) is an original product of Janssen Pharmaceutica, Belgium, and co-developed by Ortho Pharmaceutical Corporation.

ORTHO

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ritan, New Jersey 08869

OJ-1511

A timely review and update of the clinical implications of abnormal alterations of this important cation.

A Clinical Review of Magnesium Metabolism

JOHN H. KOVACICH, M.D., and THEODORE HERSH, M.D., *Atlanta**

In the last 10 years, there has been extensive experimental and clinical research into magnesium, which may be called the "cation of the seventies." The following is a brief, clinically-oriented review of one of the frequently overlooked electrolytes, magnesium.

Magnesium is the fourth most abundant cation of the body following calcium, sodium, and potassium. It is second only to potassium as the most abundant intracellular cation. The "imaginary" 70 kilogram man possesses 2,000 milliequivalents of magnesium; half of it is stored in bone, while the other half is found in muscle and soft tissue. The intravascular space contains less than 1% of the total body content of magnesium, yet this is the compartment which we most frequently measure to determine state of magnesium stores.

The normal serum concentration is 1.4-2.5 milliequivalents per liter. Its determination in most clinical laboratories may be performed in 30-45 minutes at a reasonable cost. Since serum levels may be maintained in the face of significant total body magnesium depletion, a more sensitive assay has been sought. Muscle biopsy and urinary excretion precisely reflect magnesium stores. The latter is a more practical determination: when a patient excretes less than six milliequivalents of magnesium in a 24-hour urine specimen, magnesium depletion is likely, since the kidney is attempting to preserve this cation, reflecting tissue levels. Low urinary levels indicate a need to investigate the cause of magnesium depletion, with subsequent need to initiate appropriate therapy.

* Dr. Kovacich is Senior Medical Resident, and Dr. Hersh is the Co-Director of the Division of Gastroenterology at Emory University School of Medicine. Their address is Department of Medicine, Emory University School of Medicine, Atlanta, GA 30322.

The average daily intake of magnesium is 25 milliequivalents, most of it derived from green vegetables. Chlorophyll in green plants is rich in magnesium, just as hemoglobin is rich in iron. Approximately one-third of the magnesium ingested is absorbed, primarily in the small bowel, while the remainder is excreted with the stool. In magnesium-depleted states, the kidney conserves the cation, with losses in urine of less than one milliequivalent per day. For this reason, the absolute daily requirement varies with the clinical state of the patient, primarily as it pertains to the renal and gastrointestinal losses.

The biochemical importance of magnesium is evidenced by its need in activating various enzyme systems which generate adenosine triphosphate, regulators of cellular metabolism. Magnesium is also necessary for DNA and protein synthesis via its role in amino acid activation and aiding the binding of mRNA to ribosomes.

Table 1 shows the clinical spectrum where hypomagnesemia may be encountered. The most common causes of magnesium depletion are various gastrointestinal disorders. Malabsorption may result in a failure to absorb adequate amounts of magnesium and in some of these syndromes, there may be concomitant magnesium secretion into the gut. Also, in malabsorption syndromes, magnesium binds to fatty acids and is thus unavailable for intestinal absorption. Attacks of acute pancreatitis may result in the formation of magnesium soaps in the mesentery in areas of fat necrosis, with consequent decrease in serum and tissue levels of magnesium. Intestinal fistulae and inflammatory bowel disease may result in hypomagnesemia from increased losses of the ion in the stool. In contrast, the hypomagnesemia noted in the cirrhotic patient is due to increased magnesium urinary losses secondary to

TABLE I—MAJOR CAUSES OF HYPOMAGNESEMIA

- A. Gastrointestinal Disorders
 - 1. Malabsorption syndromes
 - 2. Enteric fistulae
 - 3. Prolonged nasogastric suction
 - 4. Protracted diarrhea
 - 5. Acute pancreatitis
 - 6. Cirrhosis
 - 7. Malnutrition
- B. Renal Disease
 - 1. Glomerulonephritis
 - 2. Renal tubular acidosis
 - 3. Pyelonephritis
 - 4. Nephrosclerosis
- C. Endocrine Disorders
 - 1. Hyperaldosteronism
 - 2. Hyperparathyroidism
 - 3. Diabetic ketoacidosis
- D. Alcoholism
- E. Diuretic Therapy

hyperaldosteronism. In the alcoholic patient with liver disease, there may also be a decrease in dietary intake. Prolonged administration of intravenous fluids without magnesium repletion, particularly associated with nasogastric suction, may also result in hypomagnesemia. Patients maintained on standard hyperalimentation fluids usually receive adequate amounts of magnesium.

Hyperparathyroidism results in a negative magnesium balance because of large losses of the ion in the urine. Some investigators feel that there is a negative feedback mechanism involving magnesium and parathyroid hormone, whereby rising magnesium levels cause a fall in parathyroid hormone and a decrease of mobilization from bone. Hyperaldosteronism results in hypomagnesemia secondary to increased losses both in urine and feces. Cases of hypomagnesemia and recurrent tetany have been corrected by removal of an aldosterone secreting tumor. In diabetic ketoacidosis (DKA), hypomagnesemia ensues from large urinary losses. Just as the potassium may be falsely elevated in acidosis, so may the magnesium, with the serum level falling rapidly as magnesium shifts back intracellularly with the correction of the acidosis. Five milliequivalents per liter of magnesium may be added to the intravenous fluids during therapy for DKA.

Alcoholism results in lowering of magnesium levels via several mechanisms. As alcohol levels are rising in the blood, there are increased urinary losses. Frequently in alcoholics, there is also a decreased oral intake of food. If there is associated vomiting, there may be additional losses of magnesium. As noted, the secondary aldosteronism accompanying cirrhosis also causes increased urinary losses. In a patient with delirium tremens, the neurologic symptoms of magnesium depletion may be masked.

Diuretics may cause hypomagnesemia due to increased urinary losses. Since many of these patients are also on digitalis glycosides, the physician must be cautious. Hypomagnesemia predisposes to significant hypokalemia.

A wide spectrum of renal diseases may result in abnormalities of magnesium levels. Magnesium is normally filtered at the glomerular level and reabsorbed at the tubules. When a patient with normal renal function is deprived of magnesium, the kidneys will conserve the electrolyte so that the urinary losses are less than one milliequivalent per day. Glomerulonephritis, pyelonephritis, hydronephrosis, and nephrosclerosis may, early in the course of the disease, cause hypomagnesemia. However, as the glomerular filtration rate continues to fall, progressing to end stage renal disease, hypermagnesemia supervenes. This is also contributed to by the administration of magnesium-containing antacids to the patient with renal failure. Clinically, hypermagnesemia may result in depression of the central and peripheral nervous system with loss of deep tendon reflexes, quadriplegia, and a possibility of respiratory paralysis. Dialysis will result in rapid lowering of the serum magnesium level with reversal of these symptoms. Lowering of the serum magnesium with dialysis may also contribute to the clearing of the sensorium which accompanies dialysis in the encephalopathic patient.

A high frequency of hypomagnesemia has also been found in children with protein-calorie malnutrition (Kwashiorkor). Magnesium depletion under these conditions probably results from a combination of inadequate food intake and increased losses via vomiting and diarrhea. When these children are protein repleted, magnesium is also required to return their growth curves to normal.

"Clinically, hypermagnesemia may result in depression of the central and peripheral nervous system. . . ."

What is the importance of magnesium depletion? Generally, before the patient becomes symptomatic, the serum level must fall below one milliequivalent per liter. Some patients may have low serum levels without clinical evidence of magnesium depletion. In the depletion states with associated symptoms, there is a tissue loss, because the net deficit is significantly greater than the total amount of extracellular magnesium.

There is no specific syndrome classical for hypomagnesemia, but rather a spectrum of diverse metabolic, neurologic, gastrointestinal, and cardiovascular manifestations. It is felt that the development of symptoms reflects the attainment of critically low tissue levels which interfere with cellular metabolism via alterations of enzyme function.

Its effect may also be felt by concomitant low levels of potassium and calcium.

Gastrointestinal symptoms which may be produced by hypomagnesemia include anorexia, nausea, and vomiting, and occasionally progression to a paralytic ileus. Under these circumstances one should correct the primary problem at the same time as replacing the necessary ions, including magnesium.

Neurologic symptoms are not uncommon. There may be lethargy, and weakness may progress to complete areflexia. The other end of the spectrum of magnesium depletion includes tremor, ataxia, seizures, and tetany. Hypomagnesemia may also cause overt psychosis. It is impossible to distinguish the tetany of hypomagnesemia from the tetany of hypocalcemia. Chvostek's and Trousseaus' signs may be present in either condition. The tetany may be corrected by use of magnesium alone but not by calcium, since magnesium is required to allow parathyroid hormone to release calcium from bone.

The metabolic derangements which result from hypomagnesemia are primarily those of calcium and potassium. There may be hypocalcemia and/or hypokalemia refractory to replacement of these specific cations but responsive to the administration of magnesium. The refractory hypokalemia is felt to be due to persistent renal losses of potassium in the absence of adequate magnesium. The hypocalcemia is thought to stem from the bones' unresponsiveness to parathyroid hormone in the absence of magnesium.

The spectrum of heart disease seen in the magnesium-depleted state is broad. Patients with alcoholic cardiomyopathy are frequently hypomagnesemic. Whether the hypomagnesemia or the direct toxic effect of the alcohol plays the greatest role is much debated; however, investigators have induced direct myocardial damage which progressed to fibrosis in experimental animals deprived of magnesium. The mechanism of injury has been postulated to be an absence of magnesium dependent enzymes which are involved in oxidative phosphorylation.

Many theories have been postulated concerning the role of magnesium in ischemic heart disease. In areas of the country where there is soft water (low calcium and magnesium content), there is a greater incidence of ischemic heart disease and sudden death. Ionic magnesium has been shown to decrease blood lipid levels and affect coagulability, so that in this manner magnesium may affect development of coronary disease.

The electrocardiographic changes of hypomagnesemia are nonspecific but important. With mild magnesium depletion, there may be prominent *u* waves and peaked or bifid *t* waves. As the hypomagnesemia becomes more severe, one may see prolongation of the PR interval, widening of the QRS complexes, ST depression, and a prolonged QT interval. Hypomagnesemia may also produce disturbances in cardiac rhythm. Whether this is a direct effect or acts through its hypokalemic effect is unknown. However, in the face of hypomagnesemia, less digitalis is required to cause toxicity. Arrhythmias resulting from digitalis toxicity in dogs were terminated by the infusion of magnesium. Thus it seems wise to obtain magnesium as well as potassium levels in patients suffering from digitalis intoxication and associated arrhythmias and to administer magnesium and potassium salts as indicated to replete the patient. Hypokalemia in the presence of hypomagnesemia does not respond to potassium replacement therapy alone.

How should therapy of the patient with hypomagnesemia be undertaken? The most important point is consideration of the diagnosis and, therefore, direct therapy to the primary disease causing the magnesium-depleted state. After the appropriate laboratory studies have been obtained, the deficiency may be replaced intravenously, intramuscularly, or enterally. Table 2 shows a schema for magnesium replacement in adults with normal renal function.

TABLE 2—SCHEMA FOR MAGNESIUM THERAPY IN ADULTS

Intramuscular 50% $MgSO_4$:
Day 1: 4cc every 2 hours for three doses, then every 4 hours for four doses.
Day 2: 2cc every 4 hours.
Day 3: 2cc every 6 hours.
Intravenous 50% $MgSO_4$:
Day 1: 12cc in 1000cc D_5W over 3 hours, followed by 10cc in 1000cc D_5W 2 liters over next 20 hours.
Day 2-5: 12cc distributed equally in the days' total intravenous fluids.
Oral Therapy Magnesium Oxide
250-500 mg. four times daily.
Decrease if diarrhea occurs.

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The true mechanism involved in preventing paralytic episodes remains unclear.

Periodic Paralysis With Thyrotoxicosis— Treatment With Propranolol

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Introduction

THYROTOXIC periodic paralysis is a well-described clinical disorder,[1, 2, 4] but there is very little known about the pathophysiology. It appears primarily in orientals,[1, 2] occasionally with familial grouping,[3] and rarely in blacks.[2, 4] A few physicians have been successful in preventing paralytic episodes with the use of propranolol,[8, 9] but the mechanism is not clear. The following is a report of a typical case of hypokalemic periodic paralysis associated with thyrotoxicosis, and describes our attempt to improve muscle strength during an acute attack with the use of propranolol.

Report of a Case

A 42-year-old black man was admitted to the Veterans Administration Hospital in Atlanta on Jan. 28, 1978, for evaluation of severe muscle weakness. Two weeks earlier he had suffered a less severe episode of muscle weakness. The abrupt onset occurred 2 hours after an evening meal rich in carbohydrates. The weakness was more marked in his legs than his arms. He fell while attempting to rise from a chair and was barely able to crawl to his bed. The entire episode lasted approximately 1 hour. He did not lose consciousness, had no seizure activity, and his speech, mental function, and sensation were apparently unaffected. He denied any alcohol intake or strenuous activity on the day of the episode. The next afternoon he had the abrupt onset of a similar episode in which he could not stand for almost 24 hours and could not walk for 48 hours. On the evening prior to admission, a similar but more severe episode occurred. He had no difficulty breathing, but attempts to cough were very weak, and his ability to move was limited to his head and mouth.

The patient reported a 15-pound weight loss in the preceding 6 months, and a 2-to-3 month history of increased nervousness and sweating. There was no history of oriental ancestry. The patient had been treated for an active duodenal ulcer on two occasions. On May of 1977, the ulcer improved with antacids, and in November of 1977, the ulcer improved with cimetidine and antacids.

Physical examination revealed a slender, well-developed man who was obviously restive but extremely weak. The pulse was regular at 84 beats per minute, with hyperdynamic peripheral pulses; blood pressure was 135/75 mm Hg and strength was assessed as 3/5 in the upper extremities and 2/5 in the lower extremities. There were no fasciculations. Deep tendon reflexes were absent in the legs and normal in the arms. The sensory examination was unremarkable, and cranial nerves were intact. A fine intention tremor of the hands was noted. The thyroid was firm and mildly enlarged. The skin was smooth, warm, and moist.

Laboratory data included serum sodium, 144 mEq/liter; serum potassium, 2.0 mEq/liter; serum chloride, 109 mEq/liter; carbon dioxide combining value, 27 mEq/liter; BUN, 14 mg/dl; and serum glucose, 135 mg/dl. Creatinine phosphokinase (CPK) was 56 IU/liter (nl 21-160 IU/liter); and serum cortisol, 5.2 μg%. Electrocardiograms contained short PR intervals, long QT intervals, and

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prominent U waves. Another serum potassium level, determined prior to therapy, was 1.6 mEq/liter. He was given 40 mEq of potassium chloride by mouth and an infusion of one-half normal saline in 5% dextrose with 20 mEq of potassium chloride added to each liter at a rate of 125 cc/hour. Approximately 10 hours after admission, serum sodium was 146 mEq/liter; serum potassium, 5.1 mEq/liter; serum chloride, 108 mEq/liter; and carbon dioxide combining value, 29 mEq/liter. A 24-hour urine collection on the day of admission contained 599 mEq of sodium and 107 mEq of chloride. After 24 hours, his motor strength was markedly improved; however, he could not walk until the end of the second hospital day. Thyroid studies later indicated that resin triiodothyronine (T_3) uptake was 34.5% (nl 25-35%); triiodothyronine radioimmunoassay, 3.5 ng/ml (n 1.2-2.3 ng/ml); thyroxine (T_4) 16.9 μg/dl (nl 4-11 μg/dl) free thyroxine (T_4) index 19.26 (nl 3.7-12.42). Over 24 hours, thyroidal I^{131} uptake was 38% (nl 15-35%) and radionucleotide scanning revealed mild diffuse enlargement of the thyroid gland. Antithyroglobulin antibodies were negative, and antimicrosomal antibodies were positive at 1 : 100 dilution. A muscle biopsy of the quadriceps femoris showed no abnormality to light microscopy, and there were only a few patchy areas of myofibrillar degeneration and prominent T system tubules on ultrastructural examination. No vacuolization was noted. An oral glucose tolerance test was performed after 6 days of hospitalization, and the insulin response was normal (Figure 1). The patient was placed on 100 mg of propylthiouracil every 6 hours and discharged.

Propranolol has been found to prevent the action of catecholamines by blocking peripheral beta-adrenergic receptors . . . (and to suppress) insulin release.

For 4 weeks, no attacks of weakness were noted, but his profuse sweating and level of anxiety did not abate. On March 6, 1978, he again began to feel weak after a normal day of sedentary activity. The next morning he could not lift his legs from the bed. He was again admitted to the Veterans Administration Hospital, and his strength was judged to be 4/5 in the arms and 3/5 in the legs. He still appeared mildly thyrotoxic, with a regular initial pulse of 120 beats per minute, and a blood pressure of 140/85 mm Hg. The serum potassium was 2.5 mEq/liter; serum calcium, 9.1 mg/dl; and serum magnesium, 2.1 mg/dl. Over 24 hours, his urine contained 94 mg of magnesium and 170 mg of calcium. Resin T_3 uptake was 31%; T_4 13 μg%; and free T_4 index 12.48. He was given 40 mg of propranolol by mouth, and 6

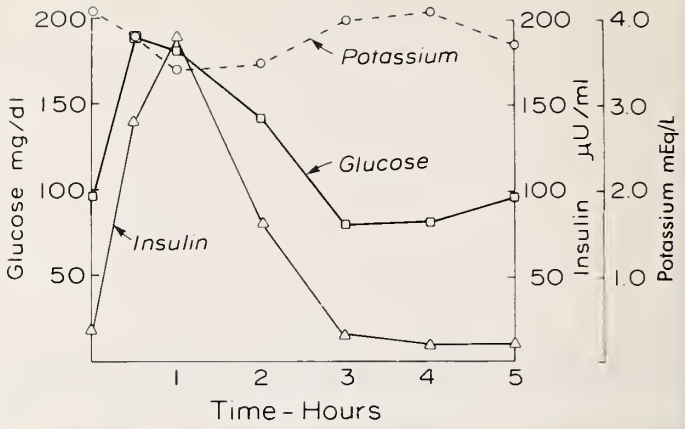


Figure 1 — Oral glucose tolerance curve with insulin and potassium values.

hours later his grip strength was not significantly altered. His serum potassium had risen from 2.5 to 3.5 mEq/liter without any exogenous potassium administration. At that time an infusion of 40 mEq of potassium chloride was begun, and 8 hours later his strength had improved by 20 kg in each hand. His serum potassium was 4.6 mEq/liter. Despite this mildly increased strength and subjective improvement, he was not able to ambulate for 36 hours. This was similar to the sequence of the previous episode. He has been maintained on propranolol, 40 mg every 6 hours, and propylthiouracil, 100 mg every 6 hours, and has experienced no more episodes of hypokalemia or weakness.

Comment

The clinical presentation of this case is similar to those reported by other authors, with the exception of the lack of typical vacuolization seen in muscle biopsy specimens. However, this minor inconsistency is not enough to postulate other clinical disorders. This case also differs from many others previously reported in that the patient had not engaged in any strenuous activity before the onset of weakness.

Little is known about the mechanism of periodic paralysis. Episodes may be precipitated by infusions of insulin and glucose,[6] previous strenuous activity,[4] epinephrine, and in some cases, acetazolamide.[8] Attacks are prevented invariably by the euthyroid state[1] and inconsistently by the prophylactic use of potassium chloride salts,[1, 8] aldosterone antagonists,[1, 8] and propranolol.[8, 9]

Shishiba[5] reported one patient in whom insulin levels were elevated prior to a paralytic episode. Yeung[8] also found one patient in whom, during induced paralytic episodes, insulin levels were elvated prior to propranolol therapy, and suppressed in later unsuccessful attempts to induce paralysis after propranolol. However, this was not the case in their other patients, and no conclusion could be made

TABLE 1 — Effect of Propranolol on Motor Strength, Serum Potassium, and Vital Signs

Time (Hours)	Pulse (Beats per Minute)	Blood Pressure (MM of Mercury)	Strength (Pounds of Force) (R)	(L)	Potassium Serum K+ (mEq/L)	Propranolol Dosage	KCL Infusion 40 mEq/L
0	92	140/85	60	42	2.5	40 mg po	
2	92	125/65	58	45	3.3		
4	84	125/65	50	50	3.5		
6			60	35			
8	80	116/70	43	30		40 mg po	
12	72	108/66	70	54	4.2		
14	72		80	66	4.6	40 mg po	

implicating insulin-precipitating paralysis. Our patient did not demonstrate an abnormal insulin response to an oral glucose tolerance test and did not experience an attack of weakness.

Yeung et al.[8] reported that paralytic episodes were prevented in four of seven patients who were pretreated with propranolol for 6 days despite the occurrence of hypokalemia. Propranolol has been found to prevent the action of catecholamines by blocking peripheral beta-adrenergic receptors.[7, 12] Other actions include the suppression of insulin release,[10] and reducing the potentiation of the effect of thyroid hormone and catecholamines in their stimulation of adenyl cyclase.[12] Adenyl cyclase induces adenosine triphosphate hydrolysis which results in increased cyclic adenosine monophosphate which may induce a hypermetabolic state.[7] Thyroid hormone also stimulates the sodium and potassium active transport system bound to the plasma membrane,[7] but it is not known whether propranolol affects this mechanism.

By giving propranolol acutely during an attack, we were hoping to demonstrate some relation between muscle strength and the beta-adrenergic catecholamine stimulation found with thyrotoxicosis. The failure to improve muscle function does not confirm blocking of beta receptors as a mechanism for the treatment of paralysis with propranolol as suggested by Conway.[9] This supports a report by Resnick et al.[6] who found that treatment with reserpine controlled tachycardia and nervousness, but failed to prevent periodic paralysis. Forty milligrams of propranolol orally may not have been enough to produce adequate beta-blockade, even though there was substantial decrease in pulse and blood pressure (Table 1).

We were unable to record postural pulse changes because of the patient's weakness. Responses to Valsalva maneuvers may have given additional information but were not performed. Nevertheless, we conclude that propranolol apparently has little effect on reversing periodic paralysis once the attack has occurred. Its primary role is prevention of the attack. More detailed and controlled studies are required to determine if the effect of propranolol is mediated through insulin suppression, inhibition of adenyl cyclase, or some other mechanism.

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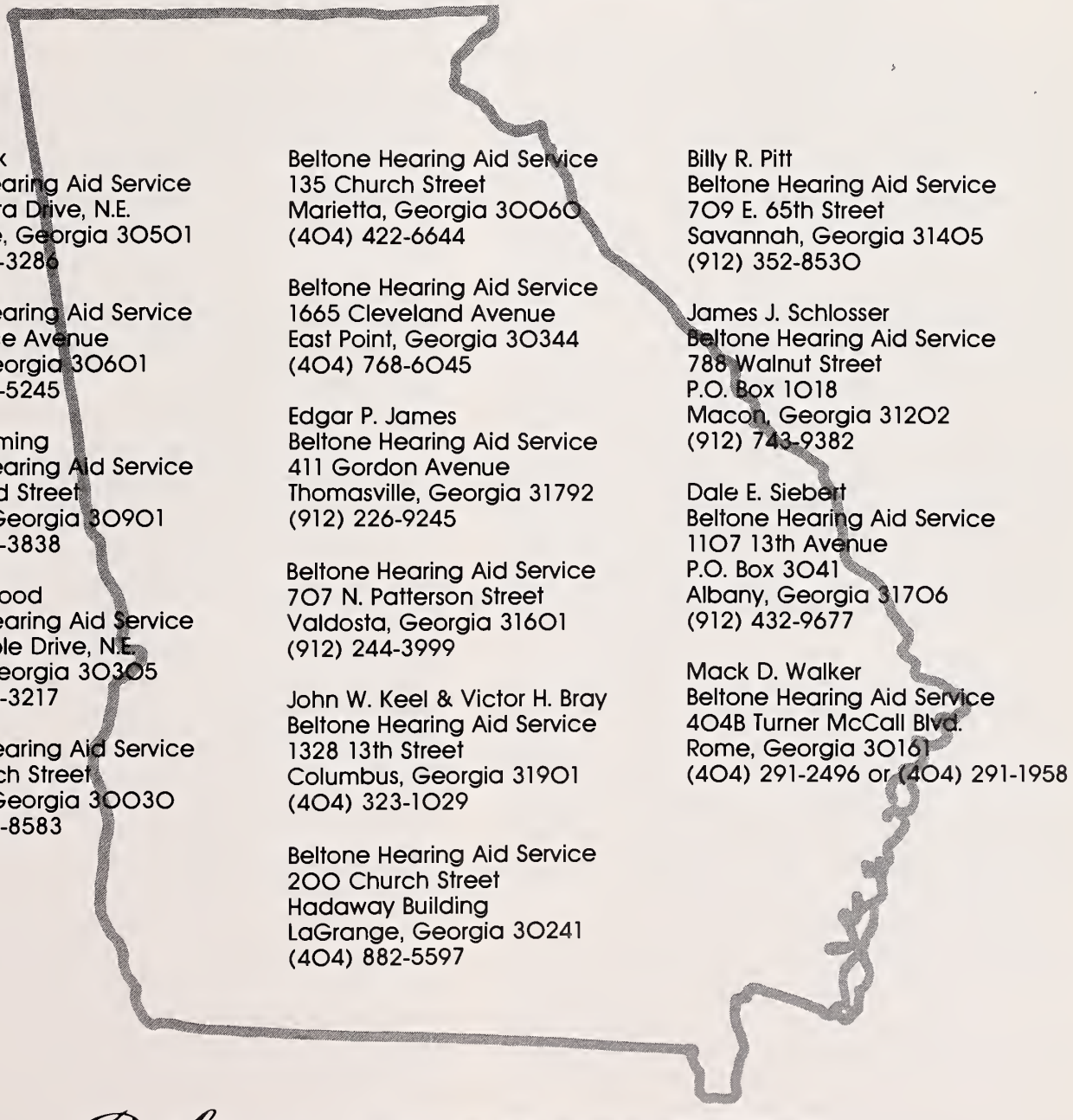
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The author discusses the necessity of communication for a more effective practice of the medical art.

The Magic Word in the Effective Practice of Medicine

G. R. FOSTER JR., M.D., *McDonough**

I SHALL TRY to touch briefly on a somewhat philosophical subject as it applies to medicine. It is a tool of vital importance that each of us is compelled to use on a daily basis, with a greater or lesser degree of skill, and one that receives less emphasis and attention than its importance deserves, and that is the fine art of communication. The degree to which we are skillful in its use is quite often a major determinant in the success or failure of our delivery of quality health care.

We communicate in so many ways. These past 2 days have been an effort to communicate some of what is new and best to each other. There are few occupations in which such a monumental effort is made by its practitioners to educate each other with the sole aim of improving the quality of its service. This is surely one of our finest endeavors, one that by and large we do well — sometimes brilliantly — and one that certainly we are doing more and better each year. This, I think, as much as any one thing we do, earns us the right to the title of "profession."

Certainly one of our most important professional roles is that of listener. It is also one of the most difficult and demanding. It is not passive. It is both manipulative and interpretive. We tend to think of communication in primarily verbal terms. If taking a personal history were merely a passive art with a purely verbal medium, all we would have to do is furnish the patient with pen and paper.

It is here that there are so many subtleties and nuances. We use the terms "gut reaction" and "instinct" to explain those flashes of wisdom that sometimes guide us past narrowly missed pitfalls and errors. I submit that these are neither gastrointestinal nor intuitive functions. They are the result of the combined impact of multiple forces of intellect, training, and experience and the somewhat intangible component of communication skill. It is this that troubles me about the tendency to delegate more and more of this responsiblity to physicians' assistants, nurses, and others of those around us. The condition of a patient who is seen during an influenza epidemic with fever, malaise, cough, and vague chest discomfort, but who instead of influenza has had a myocardial infarction and is in congestive heart failure, is not recognized as the result of a simple recitation of symptoms.

". . . [listening] is not passive. It is both manipulative and interpretative."

It is almost impossible to touch on this subject without inveighing Sir William Osler's plea to "listen to the patient." It is old, and in spite of the overwhelming array of technology we have available, that admonition is no less true today than then. Indeed, since so many aggressive and invasive procedures are available, with huge potentials for both help and harm, the art of listening and communicating has become even more important. In Sir William's day, physicians were often unable to change the course of a disease, so that much of the time accurate diagnosis was an academic exercise. Not so now. A patient's personal history should be utilized to the fullest, so that when combined with objectivity, a reasonable assessment can be drawn, and a rational plan as to treatment can be developed. Otherwise, the initial management of a patient's illness may well be inadequate, with the cost measured in both time and money and possible morbidity related to unnecessary diagnostic or therapeutic adventures.

* Dr. Foster is President of the Association of Surgeons of the Southern Railway System. This is part of his address at their meeting in April 1979 in Charleston, S.C.

Medical records not infrequently include the term "poor historian." Very often that is a misdirection of blame. If we attempt to function as listeners after first imparting a sense of time urgency, as we all often do, we have already diminished, and sometimes destroyed, the patient's ability to communicate an undistorted history and to maintain some sense of perspective. Whether deliberately or inadvertently, we inevitably communicate to the patient the presence or absence of genuine interest, concern, and the time to listen. Without these, no patient is a good historian.

I must admit that sometimes those of us in the trenches are engaged in some intriguing exercises in imprecision. "Where does your stomach hurt?" — "All over." "When did it start?" — "A long time ago." "How long?" — "Not too long." "When was your last menstrual period?" — "Last month." "When last month?" — "Saturday before the third Sunday" — and on and on.

". . . sometimes those of us in the trenches are engaged in some intriguing exercises in imprecision."

We must take the active role in communicating to the patient and his family. Yet here is where we sometimes function the poorest. And again, it is not merely what we say that is conveyed to the patient. Our tone of voice, facial expression, gesture, body language in general, even what is not said, can transmit indifference, impatience, irritation, time urgency, frustration, fear, even hostility.

We have all heard patients say, "He was in and out so fast I forgot what I wanted to ask him" or, "I just couldn't understand what he was telling me." I often serve as either interpreter or information liaison between the patient and the various specialists to whom I refer them. It is commonplace to have a patient call me from his hospital bed and ask that I call the attending physician to find out what is going on, or to attempt to solve some other type of problem resulting from a breakdown in communication. Too often a lonely, frightened patient comes to feel even more isolated in an alien environment that he perceives as not listening to him.

We must explain the technicalities of disease and injury, make diagnostic or treatment procedures rational and comprehensible, instruct the patient in what he must do for himself so that he does it accurately and willingly, allay unnecessary apprehension, and in some instances help the patient understand and accept living with disease and disability. Volumes could be written on physicians' communication problems with death and dying.

Then there is the problem of communication within the team participating in the patient's care. Where more than one physician is involved, there is almost always some degree of conflicting information that must be resolved. Otherwise, confusion, loss of confidence, even hostility are inevitable. Inaccuracy and error can develop easily as information passes through many echelons of medical hierarchy down to the patient.

Equally important is the transmission of information to each other via the medical record. This has been the focus of a great deal of recent attention. Dr. Weed has given us an entirely new system of record keeping with such widespread acceptance that the "Problem Oriented Medical Record" and S.O.A.P. have become a universal language. But no matter what the system, success requires quality in both the transmitter who makes the record and the receiver who reads it. As in the often quoted truism about computers — "garbage in, garbage out."

As physicians, we communicate to the world around us, and, unfortunately, not always well. The press tends to give front page attention to the dramatic and to the evil. Exotic procedures such as surgery to separate Siamese twins, heart transplants, restoration of amputated extremities, and the like, get the positive attention. On the negative side are Medicaid fraud, income tax evasion, malpractice, strikes — all the products of a minute fraction of the profession, but they tarnish us all. The real workaday world of medicine does not make good copy and just does not come across to the public.

But the great majority of contacts between the public and the profession are still at the one-to-one level. So that each one of us with each patient contact contributes something for good or for bad to what the public perceives us to be. The quality of that contribution is to a great degree the product of our ability to communicate well.

Think back to the last time you unexpectedly called a patient to see if he was feeling better or called on a former patient now in a nursing home. Remember what sort of response that action provoked. It is this type of thing that so simply and eloquently communicates real warmth and genuine concern. That patient is not likely to characterize us all as money-hungry ogres, addicted to country clubs, golf, and European trips. Nor is he likely to find cause to initiate groundless malpractice suits, or join the mob action to put the whole profession in the hands of bureaucrats.

Each of us needs to be reminded how much the ability to communicate tempers the results of our efforts, and of the necessity to continuously struggle to upgrade our capabilities. To the extent that we are successful, we shall have improved the state of the art.

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A discussion of the various methods of diagnosis and treatment of this disease is presented.

Office Management of Diabetes Mellitus

L. HARVEY HAMFF, M.D., F.A.C.P., *Atlanta**

Abstract

A discussion of the pitfalls in the diagnosis of diabetes mellitus is presented. Drugs which may affect the glucose tolerance test and the role of the glucose tolerance test in the diagnosis of diabetes mellitus are discussed. Diabetes mellitus is a heterogeneous disease, and treatment must vary depending on which group the patient fits. The importance of dietary management is stressed. In juvenile onset, ketotic prone diabetics, the majority will require split doses of an intermediate acting insulin. Problems relating to insulin lipodystrophy are discussed.

Diabetes mellitus is a chronic disease. Under most circumstances, it will remain present for the duration of the diabetic's life and will require supervision. Hospitalization may be necessary during the initial treatment of the diabetic and also for some of the complications that might occur, but the long-range management and control of the diabetic should be in the domain of the physician's office. When first seen, an adequate history and physical examination, along with appropriate laboratory tests, should be obtained. It is essential that an accurate diagnosis of diabetes mellitus be made before treatment is instituted. I have seen patients treated for diabetes where the diagnosis was made incorrectly based on only the presence of glycosuria, or on an abnormally elevated blood sugar which later was found to be due to a laboratory error. Diabetes is also misdiagnosed when the patient is not properly prepared for the glucose tolerance test. If the person has been on an inadequate carbohydrate and caloric intake prior to the test, an abnormal diabetic-like curve can result. When I use this test, I put the patient on a 300 gm. carbohydrate diet for 3 days and restrict any medications which would affect the curves.

Certain commonly used drugs will adversely effect the glucose tolerance test and may be the cause for an incorrect diagnosis. Table 1 shows a partial list of drugs with hyperglycemic action. Diuretics, oral contraceptives, and steroids are by far the most common ones encountered. They should be discontinued before performing a glucose tolerance test. Large doses of salicylates and some monamine oxidase inhibitors act as hypoglycemic drugs and could possibly produce a normal glucose tolerance test in a mild diabetic. An incorrect diagnosis of this disease may also result if the test is obtained at the time of stress and should not be performed at the time of acute infections, surgery, fractures, or acute myocardial infarctions.

The glucose tolerance test should not be performed as a routine test for the diagnosis of diabetes mellitus. On many occasions I have seen the test performed when only fasting blood sugars were necessary to make the diagnosis. This is a diagnostic test and should not be used as a guide for treatment. Although the test is usually harmless, under some circumstances where the fasting blood sugar is unusually high, the addition of 75 to 100 gm. of glucose could raise the blood sugar level so high that a

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TABLE 1 — Drugs with Hyperglycemic Action

A. COMMONLY ENCOUNTERED
 1. DIURETICS
 a. Thiazides
 b. Chlorthalidone (Hygroton)
 c. Furosemide (Lasix)
 d. Ethacrynic Acid (Edecrin)
 e. Acetazolamide (Diamox)
 2. ORAL CONTRACEPTIVES
 3. STEROIDS
B. LESS COMMONLY ENCOUNTERED
 1. Diazoxide
 2. Nicotinic Acid
 3. Nalidixic Acid (NegGram)
 4. Nitrofurantoin (Furadantin)
 5. Diphenylhydantoin (Dilantin)
 6. Glucagon
 7. Heparin
 8. Tricyclic Antidepressants
 9. Indomethacin (Indocin)
 10. Reserpine
 11. Lithium Carbonate
 12. Catecholamines
 13. ACTH
 14. Growth Hormone

non-ketotic hyperosmolar coma could be precipitated. A considerably elevated fasting blood sugar on at least two, and preferably three, occasions will substantiate the diagnosis of diabetes mellitus. Some investigators[1] feel that the glucose tolerance test is useless and should not be performed. They argue that the diagnosis of diabetes should not be made without fasting hyperglycemia. The majority of diabetologists, however, do use the glucose tolerance test as a diagnostic tool. The finding of borderline to slightly elevated fasting and 2 hour postprandial blood sugars are good indications for performing a glucose tolerance test. Other indications would be a high index of suspicion, such as a woman who delivers a 10 lb. baby or a patient with a family history of diabetes.

Table 2 shows criteria for an abnormal glucose tolerance test. Criteria for an abnormal test by Fajans and Conn would be a test equal to or higher than all three values.[2] The U.S. Public Health Service gives points, with one point for the fasting and 3 hour determinations and ½ point for the 1 and 2 hour tests.[3] If the total is two points or more, an abnormal test results. The University Group Diabetes Program (UGDP) is a summation test. The sum needs to be greater than 582, or 500 if one were determining whole blood sugars instead of plasma levels.[4]

There are a range of values which are somewhat abnormal, but which would not be definitely diabetic. The terms latent, pre-diabetic, and chemical diabetes have all been used to describe this kind of case, which is usually asymptomatic. I prefer to call it carbohydrate intolerance by glucose tolerance testing. As many as 75 to 80% of these individuals may not decompensate and become overt symptomatic diabetics. I believe great harm can occur in this population group if they are over treated.

The oral hypoglycemic agents and insulin are both contraindicated in this group. Diet alone is the proper treatment. Diet should only eliminate sweets and the rapidly absorbable sugars in the non-obese. Those who are obese should also restrict calories to obtain normal weight. Too often the oral hypoglycemic agents are used in this group of patients, particularly among the elderly, with disastrous hypoglycemic episodes. I cannot stress too strongly the avoidance of hypoglycemic agents and insulin in this group showing mild carbohydrate intolerance.

Before establishing the diagnosis of primary diabetes mellitus, secondary diabetes must be ruled out. Table 3 lists the pancreatic and non-pancreatic causes.

TABLE 2 — Criteria for an Abnormal Glucose Tolerance Test
Plasma Glucose MG/DL

Fajans & Conn[2]	U.S. Public Health Service[3]	University Group Diabetes Program[4]
Fasting	130 1 Point	X
1 Hour 185	195 ½ Point	X
1½ Hours 160		
2 Hours 140	140 ½ Point	X
3 Hours	130 1 Point	X
Criteria for Abnormal Test:		
Equal to or higher than all three values	Total of two or more points	Sum of values greater than 582

TABLE 3 — Secondary Diabetes Mellitus

A. Pancreatic Causes	B. Non-Pancreatic Causes
1. Acute Pancreatitis	1. Pituitary
2. Chronic Pancreatitis	a. Acromegaly
3. Pancreatic Malignancies	b. Cushing's Disease
4. Hemochromatosis	2. Adrenal Tumors
5. Glucagonoma	a. Cushing's Syndrome
6. Pancreatectomy	b. Pheochromocytoma
	3. Hyperthyroidism

Primary diabetes mellitus is a heterogeneous disease. Not only are diabetics divided into juvenile onset, ketotic prone group, and maturity onset, stable group, but subdivisions in these groups must be considered. The studies with HLA typing, immune responses, and viral causes in susceptible individuals make the juvenile onset group variable. Also, there are a group of juveniles whose diabetes behaves in the same fashion as the maturity onset stable diabetic and who are not insulin dependent over a period of years. They are generally asymptomatic when it is discovered, which may happen as a result of finding glucosuria or an abnormal glucose tolerance test. The maturity onset stable diabetic population is also

heterogeneous. Some are dependent on insulin, while others only require diet. Many of the obese group have an excess of plasma insulin and a decrease in receptor sites on the liver, muscle, and fat cells. These patients are diabetic not because insulin is absent, for the beta cells are functioning adequately, but because there are an insufficient number of receptor sites for insulin to bind to and allow the entry of glucose into the cells.[5] In others, reduction in insulin production is the primary problem.

Once the diagnosis of diabetes mellitus has been made, it is essential to educate the patient regarding his disease. In addition to verbal instructions, written material, including manuals and literature from the American Diabetes Association and its affiliates and chapters are available. Audio-visual slides or films are available from some hospitals and some diabetic associations. The more your patient knows about his disease, the better he will cooperate in your treatment program for him.

In regulating the diabetic patient, decide what goals you wish to obtain. Do you want to control the blood sugars to as close to normal values as possible without hypoglycemia, or do you want to control only the symptoms and not be concerned with persistent hyperglycemia? A controversy over this has raged for years. Those who favor loose control believe tight control does not prevent or delay the late degenerative complications of diabetes. Hypoglycemic episodes are not likely to occur in loose control. They believe that the complications are gene related and are not related to hyperglycemia or insulin insufficiency.

Many physicians prefer to control the diabetic to as close to the non-diabetic as possible, without hypoglycemic reactions. Laboratory and clinical evidence indicate that hyperglycemia or insulin insufficiency is harmful. The significant increase in hemoglobin A_{1c} related to hyperglycemia and its reduction with return toward normal amounts when the blood sugar becomes lowered is only one instance. The development of intercapillary glomerulosclerosis in the transplanted kidney into the diabetic recipient is evidence that it is not gene related. My approach to the regulation of the diabetic patient is that of good or tight control.

For proper treatment, all diabetic patients are on varying degrees of diet restriction. The first group I shall deal with are those who can be controlled by diet alone. This includes at least 50% of the total diabetic population. The majority are considerably overweight and will respond to a program of caloric restriction and avoidance of sugars. As they lose weight their carbohydrate tolerance improves, sometimes to the point where a glucose tolerance test might even revert to normal. The majority of these patients will require between 800 and 1,200 calories daily to achieve weight loss from 5 to 10 lbs. monthly. There are some physically active men who would lose at a satisfactory rate on 1,800 calories, whereas some inactive women of small stature might require even greater caloric restriction. If weight loss is satisfactory, there is no need to change the regimen. If weight loss does not occur and the diabetic symptoms are not under good control, more drastic measures will be necessary. These include a total fast of one week, which Davidson has found to be effective in the diabetic clinic at Grady Memorial Hospital of Emory University.[6] Elimination of carbohydrates and a restricted caloric intake from protein and fat has also been recommended. Because of its simplicity, I often place a patient on only 120 cc. of skim milk or buttermilk every 2 hours while awake for 1 week. This gives the patient between 300 to 400 calories daily. I usually restrict its use to the diabetic who is not making satisfactory progress on the conventional reducing programs, or in the patient in whom I would like to see a more rapid blood sugar lowering response.

As mentioned earlier, patients who have normal fasting blood sugars, but who show an abnormal glucose tolerance test, should only be treated with diet restrictions and not by insulin and oral hypoglycemic agents.

In the maturity onset stable diabetic group, a certain number are normal weight or are only slightly overweight. These patients should be first treated with diet alone before adding insulin or oral hypoglycemic agents. Eliminating sweets and adjusting the calories to maintain normal weight are indicated. There are various formulas to calculate the number of calories required to maintain an isocaloric state. Since physical activity differs so much from person to person, they are not necessarily accurate. In most circumstances, a housewife will require about 1,800 calories and a moderately active male from 2,200 to 2,500 calories daily. This can be adjusted upwards or downwards, depending on whether weight gain or loss is occurring.

These diets should contain approximately 40 to 50% of calories from carbohydrate, 20% from protein, and 30 to 40% from fat. This is the distribution most people prefer. If on the other hand, a person's food preferences are different, I see no reason why they cannot be carried out, except for the avoidance of sweets and rapidly absorbable sugars. Total caloric needs should not be exceeded. Although it is preferable to divide the food into three meals, they do not need to adhere to a rigid schedule. They can vary the time of their meals and on occasions miss a meal, without encountering problems. At times, they may eat more meat and less carbohydrate, and vice versa. Some diabetics can tolerate larger

amounts of carbohydrates without adversely affecting the blood sugar levels, probably by stimulating insulin release. I do think there are some diabetics whose blood sugars are controlled better with carbohydrate restriction.

There are maturity onset stable diabetics who cannot be controlled by diet alone and will require either insulin or oral hypoglycemics in addition to their diet. The use of oral hypoglycemic agents is still controversial and has been since the release of the UGDP findings and recommendations. It is not within the scope of this paper to debate the pros and cons of this controversy. The Food and Drug Administration recommends that patients requiring more than diet for management should be placed on insulin, and that the oral hypoglycemic agents should be used in the patients who for some reason cannot take insulin. Blindness, disabling arthritis, neurologic disorders with dysfunction of the hands, and psychologic problems with insulin administration are some of the reasons for using oral hypoglycemic agents. I would avoid their use in patients with known coronary artery disease.

Table 4 lists the oral hypoglycemic agents available, with their usual dosage. Table 5 lists the insulins available, with their peak action and duration of action. I would encourage everyone to use U 100 strength insulin. In the administration of insulin to this group, one should only use it if all of the dietary regimens have been tried. Usually these patients should be symptomatic with polyuria, polydipsia, or uncontrolled pruritus vulvae. The presence of symptoms referable to diabetic neuropathy with poor control would be another indication.

TABLE 4 — Oral Hypoglycemic Agents

Drug	Usual Dosage
Tolbutamide (Orinase)	500 mg. b.i.d.
Chlorpropamide (Diabinese)	250 mg. daily
Acetohexamide (Dymelor)	250 mg. b.i.d.
Tolazamide (Tolinase)	250 mg. daily

TABLE 5 — Insulins

Type	Peak Action (Hours)	Duration of Action (Hours)
Rapidly acting		
Crystalline zinc (regular)	2-3	5-7
Semi Lente	2-4	12-16
Intermediate acting		
Isophane (NPH)	6-10	18-28
Lente	6-12	18-22
Globin	6-10	18-24
Long acting		
Ultra lente	16-18	36 +
Protamine zinc (P.Z.I.)	14-20	36 +

Although the obese patients in this group may have elevated serum insulin levels and a decrease in receptor sites, the addition of exogeneous insulin would be indicated in the presence of diabetic ketoacidosis, unusually high blood sugars with possibility of non-ketotic hyperosmolar coma, and in markedly symptomatic patients. It can have a blood sugar lowering effect. It is important to remember that this group tend to be relatively resistant to insulin. Do not get trapped into the predicament of continuing to increase doses of insulin to bring down the blood sugar. I have seen patients taking as much as 120 units daily without following a proper diet, whom I was able to control by diet alone. This is an apparent and not a real need for insulin. It makes little difference if they are taking 30 units or 60 units, for hypoglycemia is not likely to develop. As they return to normal weight, many can again be managed by diet alone.

In those not obese and who cannot be adequately controlled by diet, insulin or oral hypoglycemics are indicated. The insulins indicated are either NPH (Isophane) insulin or Lente insulin. Administration of insulin is usually daily before breakfast. The requirements are usually small or moderate, less than 40 units daily. With the administration of insulin one must be on a more precise diet to prevent both hypo- and hyperglycemia. A diet instruction sheet, with a breakdown of amounts of carbohydrate, protein, and fat should be given to the patient. With the intermediate-acting insulins, the peak action is 8 to 10 hours, and usually a mid-afternoon snack is desirable. I have the patient measure the food until he is able to accurately assess the serving size by sight. I then allow estimation with occasionally measuring to be certain the estimated amounts are correct.

The management of the juvenile onset ketotic prone diabetics and those acting similarly, but developing the disease later in life is quite different from the group we previously discussed. The classical symptoms of diabetes come on explosively, and by then the glucose tolerance test is not needed. Hospitalization for 5 to 7 days is helpful in the initial regulation and education of these patients. After their symptoms have been brought under good control, the large majority will go into varying degrees of remission, with considerable decrease in the insulin requirements from the original amount required. This so-called "honeymoon period" may last anywhere from 6 to 18 months. For a while, some of these cases can even be controlled by diet alone. I prefer not to discontinue insulin in any of these for fear of having produced antibodies to a foreign protein. Later reinjection of this foreign protein may produce allergic reactions. I give as little as 2 units daily to this group. It is not uncommon for as little as 10 units of insulin to control the patient at or near an

aglycosuric and a normoglycemic state. One injection of NPH or Lente insulin before breakfast is enough to maintain control during this period of time.

After the period of remission has ended and there is no further endogenous insulin being secreted, insulin requirements increase considerably, and at least ⅔ to ¾ cannot be controlled with one injection of insulin daily. This is demonstrated by finding high fasting blood sugars and relatively normal blood sugars before the evening meal. An increase in the morning insulin dosage would bring on hypoglycemia in the afternoon, but would not control the fasting hyperglycemia. The action of the intermediate acting insulin is not long enough to control fasting hyperglycemia. This is not a Somogyi effect. Splitting the dose of the intermediate-acting insulin and giving it before breakfast and supper will afford better control. I usually begin by giving ⅔ before breakfast and ⅓ before supper and adjusting the amounts depending on blood and urine sugars. Many of this group will run elevated blood sugars between breakfast and lunch and will also require regular insulin along with the intermediate-acting insulin before breakfast. For some, this also applies to the evening dose, so that quite a few will require intermediate and regular insulin before breakfast and supper to maintain good control. I tend to use NPH insulin more often than Lente insulin, although both are equally effective. The dose should be that amount which will control the blood and urine sugars to as close to normal without hypoglycemia. An occasional diabetic who cannot be adequately controlled on both NPH and regular insulin in divided doses will come under better management with three or four injections of regular insulin daily and will continue this schedule preferentially. Admittedly, this is rare.

The majority of juvenile diabetics will require split doses of intermediate acting insulin, with or without regular insulin for good control.

Most of the juvenile diabetics are thin or normal weight. They are usually quite active physically and need sufficient calories for adequate growth and development. There is a tendency to underestimate their caloric needs. Some very active adolescent boys participating in sports may require as much as 3,600 to 4,000 calories daily. An adolescent's caloric requirements depend on age, weight, height, sex, and exercise. It is roughly estimated that the caloric needs of a child are 1,000 calories plus 100 calories for each year of age. These can be revised up or down depending on the individual's needs. Be sure to ask them if they are satisfied with their diet. It should be a well-balanced diet, and their main restriction is constancy of food intake. Mid meal and bedtime snacks should be included in their diet. Division of carbohydrates can vary according to their likes within boundaries. Division of carbohydrates with $^{2}/_{10}$ with breakfast, $^{3}/_{10}$ with lunch, $^{1}/_{10}$ mid afternoon snack, $^{3}/_{10}$ with supper, and $^{1}/_{10}$ at bedtime will be proper in most situations. Be certain their growth and development is satisfactory. In addition to diet and insulin, physical activity is the third common variable that influences the level of blood sugar. The more active one is the lower the blood sugar. This is dramatically evident with children at camp. The marked increase in activity necessitates decrease in insulin dosage to prevent hypoglycemia. Many patients learn how much extra food is required to prevent hypoglycemia and not produce hyperglycemia. This applies to the diabetic who plays any active sport. There are patients whose weekend activities differ from those earlier in the week. I recall a carpenter who was active during the week and inactive over the weekend. He required 15 units more insulin for the weekend. The patient who is sedentary during the week, but physically active over the weekend, would require less insulin for the weekend.

Have glucagon available for diabetics requiring insulin.

Glucagon is a hormone secreted by the alpha cells of the islets of Langerhans. Its action is antagonistic to that of insulin. Its hyperglycemic action can reverse the hypoglycemia induced by excess insulin. This should be reserved for insulin reactions so severe that they are unconscious and unable to swallow glucose by mouth. Its administration can save time and will prevent a trip to the emergency clinic for intravenous glucose.

After a diabetic comes under adequate control, office visits need not be more frequent than every 3 months. Initially, they may be seen every few weeks with gradual lengthening between office visits. The patient should monitor himself with urine sugar testing from two to four times daily, and bring in a record of these findings. On office visits, a fasting blood sugar and at times a blood sugar 2 hours after breakfast are obtained, and the patient is questioned regarding any problems he is having.

Periodic physical and laboratory examinations should be obtained every 1 to 2 years, and careful study should be carried out to determine whether the late degenerative complications of diabetes mellitus have developed. At this time, following the patient with hemoglobin A_{1c} determinations is not practical, but this test may become available in the near future

and will be a valuable test for monitoring the level of diabetic control.

Insulin lipodystrophy is particularly common in the young female diabetic and occurs in the hypertrophic and atrophic types. The hypertrophic type is uncommon and usually does not require treatment except for good rotation of the sites of injection. In young susceptible females it is well to advise them to use injection sites not ordinarily visible. With the widespread use of the bikinis, this may pose a real problem. The present use of single peak insulin has decreased this problem, for the atrophy has been thought possibly due to impurities in the manufacture of insulin. I would avoid using cold insulin and would have the patient not refrigerate the bottle of insulin being used. At times switching to pork insulin from the beef pork mixture is also helpful to mitigate atrophy effects. Although it is not commercially available, the use of mono-component insulin could also be helpful. Although it is not yet available, human insulin made from *Escherichia coli* bacteria by recombinant DNA techniques would probably eliminate this problem.

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Repeal of Certificate of Need Sought by MAG

The 1979 MAG House of Delegates passed a resolution which directs the MAG to seek ***repeal*** of the Certificate of Need (CON) law passed by the 1979 Georgia Legislature. By a directive of the Board of Directors, MAG took no position on the bill, which contained the minimums required by P.L. 93-641. J. Roy Rowland, M.D., a member of the Georgia House of Representatives and one totally opposed to CON, stated to the MAG House of Delegates that without CON, the Georgia-based Health Systems Agencies (HSAs) would have little power to do what they proclaim. Additionally the Georgia HSAs spend annually between $.48 and $.52 per Georgian. Add to this the budget of the State Health Planning Development Agency, and the total is approximately $3 million spent annually on HSA activities. This is a recurring yearly expense of taxpayers' money, and yet none is for direct patient care.

The assistance of every physician contacting his State Representative and State Senator asking his support in this repeal is a must if MAG is to be successful in this effort.

Update on Metabolic Screening

On Sept. 1, 1978, the Central Laboratory of the Georgia Department of Human Resources began testing for four of the metabolic disorders (phenylketonuria, tyrosinemia, homocystinuria, maple syrup urine disease) as mandated by the Georgia General Assembly earlier that year. The purpose of this communication is to give the progress to date.

Since September the Laboratory has been receiving over 9,000 samples each month for metabolic screening. During September, two cases of phenylketonuria were detected, and, recently, one case of homocystinuria. One infant was found to have non-ketotic hyperglycinemia; he had been referred to the regional genetic center because of an abnormal screening result for maple syrup urine disease. Testing for galactosemia and hypothyroidism did not begin until February 1979. To date three cases of primary hypothyroidism have been diagnosed and five suspected cases are under study.

It takes longer to report the abnormal hypothyroidism screening results than the other five disorders. When the first test result for thyroxine is below the screening level, the testing is repeated in duplicate using the same blood sample. If the second results are abnormally low, an assay is performed for thyroid stimulating hormone. It may take as long as 1 week after receiving the samples to complete this laboratory work.

The laboratory continues to receive some unsatisfactory specimens. For this reason, a slide-tape audio-visual aid was developed for training of personnel involved in collecting samples for metabolic disorders. Those interested in borrowing this educational material should contact: Clinical Chemistry-Hematology Laboratory, Division of Physical Health, 47 Trinity Avenue, S.W., Atlanta, GA 30334, (404) 656-4793.

We do not provide the equipment needed for showing this material. Equipment needed would be a 35 mm slide projector and a cassette tape player.

(Submitted by: Eve Blake, Diagnostic Chemistry Services, Georgia Department of Human Resources, and Lillian P. Warnick, M.D., Medical Consultant, Maternal and Child Health Unit)



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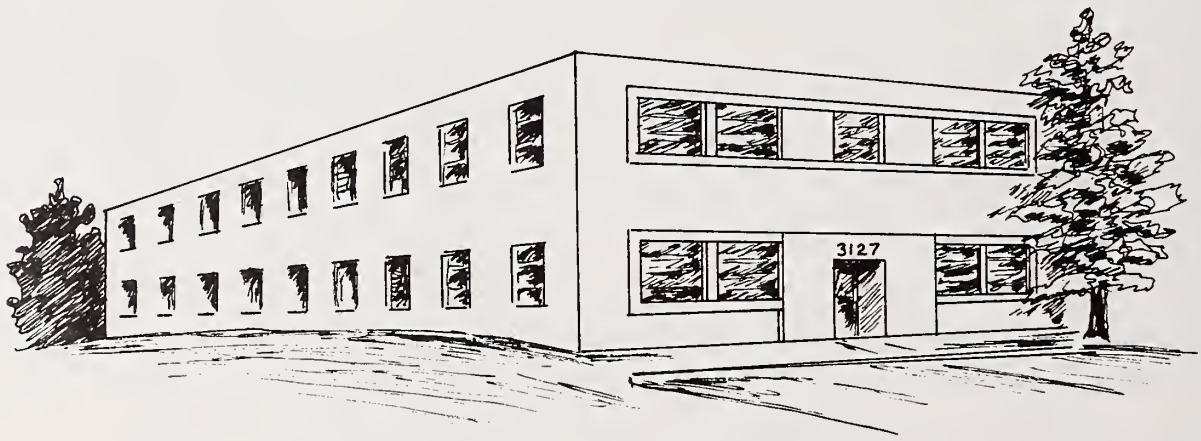
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Complete information on Peachtree and Parkwood's Adolescent Services may be obtained by writing or calling the Admissions Office, **Peachtree and Parkwood Mental Health Center and Hospitals,** 1999 Cliff Valley Way, N.E., Atlanta, Georgia 30329 (404/633-8431).

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- ☐ Surgery
- ☐ Urology

MAKE YOUR RESERVATIONS EARLY!

PLEASE RESERVE HOTEL ACCOMMODATIONS AS CIRCLED

Name _____

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Method of Payment _____ Credit Card No. _____

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Arrival Time _____ Guaranteed ☐

Reservations will be held until 6:00 p.m. unless guaranteed or covered by deposit.

Length of stay _____ nights.

Reservations received after **11-1-79** will be accepted on space available basis.

Please circle room and rate desired. If not available next room rate will be assigned.

	STD.	MEDIUM	DELUXE
Singles	$40	$45, $50	$55
Dbls./Twins	$50	$55, $60	$65
Suites (from)	$100.00		

MEDICAL ASSOCIATION OF GEORGIA
SCIENTIFIC ASSEMBLY
NOVEMBER 15 – 18, 1979

mag's 1979 Scientific Assembly

PRELIMINARY PROGRAM

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PLANNING COMMITTEE

MARK M. LINDSEY, Atlanta, *Chairman*
EDWIN C. EVANS, Atlanta
JOHN T. GODWIN, Atlanta
ARTHUR J. MERRILL JR., Atlanta
C. REX TEESLINK, Augusta
A. CALHOUN WITHAM, Augusta
STEPHEN L. DANIEL, Ph.D., *Coordinator*
MS. SUSAN F. McAVOY, *Assistant Coordinator*

MAG PROGRAM CHAIRMEN

Allergy: DAVID G. TINKELMAN, Atlanta
Allergy and Immunology Society of Georgia
Chest Disease: C. NEIL KELLEY, Gainesville
Georgia Thoracic Society
Emergency Medicine: HOYT W. CRUMP, Royston
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Internal Medicine: J. WILLIS HURST, Atlanta
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DAVID M. TAYLOR, Atlanta
Georgia Society of Internal Medicine
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Georgia Neurological Society
Neurosurgery: FREMONT P. WIRTH, Savannah
Georgia Neurosurgical Society
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Pathology: F. NORMAN BOWLES JR., Atlanta
Georgia Association of Pathologists
JACQUELINE H. WERNER, Riverdale
Atlanta Society of Pathologists
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Georgia Chapter, American Academy of Pediatrics
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Georgia Psychiatric Association
Public Health: GUNAR N. BOHAN, Decatur
Georgia Chapter, American Association of Public Health Physicians
Radiology: STEWART R. ROBERTS JR., Atlanta
Georgia Radiological Society
Surgery: EUGENE D. DAVIDSON, Atlanta
Georgia Chapter, American College of Surgeons
Urology: DAVID P. O'BRIEN, Atlanta
Georgia Urological Association

GENERAL INFORMATION

dially invited to attend the Medical Association of
5th annual Scientific Assembly on November
popular Omni International Hotel in downtown
again be the site. Scientific programs have been
the Georgia specialty societies in 16 specialties,
physician will find Category 1-accredited con-
dical education relevant to his or her practical
ndees, spouses, families, and guests will enjoy
us attractions of the Omni complex, such as the
eum (home of the Atlanta Hawks and Flames),
lds' Place, Rizzoli International Bookstore, the
k, Bugatti's, Mimi's, the French Restaurant, six
ters, and many shops, boutiques, bazaars, and
ablishments. To allow ample opportunity for
hopping, there will be no formal programs for

ATION

egister for the Assembly by completing the regis-
at the beginning of this program, detaching it
otel reservation form, and mailing it with your
fee to the MAG headquarters office.

desks at the Assembly will be located at the
al Promenade in the Convention Center of the
national Hotel. Registration hours will be Thurs-
00, Friday 7:30-3:30, Saturday 7:30-5:00, and
0-noon.

fee for MAG members is $25. The fee for non-
$50. Nurses and other health professionals will
$15. There is no fee for speakers, program chair-
al students, interns, or residents who have proper
n.

ESERVATIONS

that the bottom part of the registration form is a
ation form. If you wish hotel accommodations,
ch this form, complete it, and mail it directly to the
ational Hotel by November 1, 1979. As stated on
d, reservations will be held until 6:00 p.m. unless
or covered by deposit.

PROGRAMS

y, November 15, 9:00-12:00 noon, a seminar on
ormation and Computers will be sponsored by the
apter of the American College of Physicians. Enti-
Advances in Medical Information Transfer and
" this program should appeal to academicians,
s, librarians, and all those who are especially
n continuing medical education. The seminar is
members and guests.

es and Priorities of Medical Education in Geor-
ference for medical school representatives and
ctitioners, is scheduled for Thursday, November
00 p.m. The conference is open to all members
and is sponsored by the MAG's Committee on
nd the medical schools.

N. Onek will be the guest speaker at the Georgia
ternal Medicine Luncheon on Friday, November
k is Associate Director for the Domestic Policy Staff
e House, and his talk will be entitled "Medical
Goals of the Administration." For further infor-
se check the program on Internal Medicine. All
pouses, and guests are invited to attend.

1979 ABNER W. CALHOUN LECTURE AND MAG RECEPTION
Friday, November 16, 4:00 p.m.



"Medical Economics and Medical Ethics—the Growing Conflict"

Edmund D. Pellegrino, M.D.
President
The Catholic University of America

The cost of medical care has become a burning issue of the day for the medical profession and the public alike. Dr. Pellegrino's topic is a timely one in that it addresses the important question of whether cost containment programs are in conflict with the medical community's moral tradition of providing the best care to the patient. Dr. Pellegrino is singularly qualified to address his subject. He has had a distinguished career in medical education, serving as Dean of the School of Medicine at the State University of New York at Stony Brook, Chancellor of the University of Tennessee Center for the Health Sciences, and President of the Yale-New Haven Medical Center. He has lectured extensively and has authored some 200 articles in the fields of scientific research, medical education, and philosophy. His book *Humanism and the Physician* was published earlier this year.

All Scientific Assembly attendees, spouses, and guests are cordially invited to attend the lecture. No ticket is required. An MAG reception, open to all, will immediately follow the lecture.

SOCIAL FUNCTIONS AND TICKET INFORMATION

Luncheons have been scheduled by the Georgia Society of Internal Medicine, Georgia Chapter of the American College of Surgeons, Allergy and Immunology Society of Georgia, Georgia Thoracic Society, Georgia Neurological Society, Georgia Neurosurgical Society, Georgia Society of Ophthalmology, and Georgia Health Sciences Library Association. Please check individual specialty programs for more information.

The MAG will sponsor a reception for all attendees, spouses, and guests immediately following the Abner W. Calhoun Lecture on Friday afternoon.

Alumni receptions will be held Friday evening, November 16, by Emory University School of Medicine, University of Tennessee Center for the Health Sciences College of Medicine, and the Medical College of Georgia. The Medical College of Georgia will sponsor a dinner following its reception.

Reservations for all functions (except MAG Calhoun Lecture/Reception and Georgia Society of Internal Medicine Luncheon) should be made with the respective specialty society or alumni group. Please contact the appropriate program chairman or alumni office for more information. Information may also be obtained in the registration area at the Assembly.

Tickets for the Georgia Society of Internal Medicine Luncheon on Friday, November 16, may be ordered on the registration form in this program. All pre-paid tickets will be included in the registration packet to be obtained at the registration desk at the Omni International Hotel. A number of additional tickets will also be available on a first-come, first-served basis in the registration area at the Assembly. Information about the luncheon and guest speaker is listed under "Special Programs" in this section as well as under the program on Internal Medicine.

CREDIT

As an arganizatian accredited far cantinuing medical educatian, the Medical Assaciatian af Georgia designates all scientific programs as meeting the criteria for Categary 1 credit an an haur-for-haur basis far the Physician's Recagnitian Award of the American Medical Assaciatian. In addition, a number af sessians have been accredited by the American Academy af Family Physicians (Prescribed and Elective credit) and the American College af Emergency Physicians (Categary 1 credit). Please check each individual pragram far accreditatian informatian.

EXHIBITS

Educational exhibits will be set up in the Narth Fayer an the graund flaar af the Conventian Center at the Omni Internatianal Hatel. There will be na technical exhibits.

MESSAGE CENTER

A message center will be maintained for the canvenience of members and guests af the MAG in the registratian area.

SEMINAR ON MEDICAL INFORMATION AND COMPUTERS

Recent Advances in Medical Information Transfer and Technology

Program Chairmen

NICHOLAS E. DAVIES, F.A.C.P., Atlanta, GA
MR. MICHAEL J. TORRENTE, Assistant Director, Southeastern Regianal Medical Library Program, Atlanta, GA

Guest Speakers

LIONEL M. BERNSTEIN, F.A.C.P., Director, Lister Hill Natianal Center far Biamedical Cammunicatian, Natianal Library af Medicine, Bethesda, MD
W. DALLAS HALL JR., F.A.C.P., Prafessor of Medicine (Hypertensian), Emary University Schaal af Medicine, Atlanta, GA
NORMAN S. STEARNS, Assaciate Prafessor af Medicine and Assaciate Dean far Cantinuing Education, Tufts University Schaal of Medicine, Bastan, MA
EDWARD J. HUTH, F.A.C.P., Editar, *Annals af Internal Medicine*, Philadelphia, PA

Thursday, November 15, 9:00 a.m.

During the past decade remarkable pragress has been made in the technalagy of infarmatian starage, retrieval, and transfer. Camputers, artificial intelligence systems, videadiscs, cammunicatians satellites, and ather camplex systems have been developed ta get health infarmatian from the labaratary ta the practitianer. This is rapidly altering the traditional methads af accessing and utilizing new health infarmatian. The participants in this pragram are natianally known experts wha have been leaders in develaping these systems and in studying infarmation transfer. They will discuss their research and the develapment af these systems, their present status, and their plans for the future. The pragram shauld appeal to academicians, practitianers, librarians, and all thase wha are especially interested in continuing medical education.

Presiding:
Nicholas E. Davies, F.A.C.P.
Gavernar far Geargia
American College af Physicians

9:00-9:30

NEW MEDICAL INFORMATION TRANSFER TECHNOLOGY

LIONEL M. BERNSTEIN
Lister Hill National Center for Biomedical Cammunication
National Library of Medicine
Bethesda, MD

9:30-10:00

CLINICAL DATA BANK

W. DALLAS HALL JR.
Emory University Schaal af Medicine
Atlanta, GA

10:00-10:30

IS THERE A FUTURE FOR MEDICAL JOURNALS?

EDWARD J. HUTH
Editar, *Annals af Internal Medicine*
Philadelphia, PA

10:30-11:00

TECHNOLOGY, DATA BANKS, AND JOURNALS IN THE CONTINUING EDUCATION OF PHYSICIANS

NORMAN S. STEARNS
Tufts University Schaal of Medicine
Bastan, MA

11:00-12:00

PANEL DISCUSSION

Panel:
LIONEL M. BERNSTEIN
Bethesda, MD
W. DALLAS HALL JR.
Atlanta, GA
NORMAN S. STEARNS
Bastan, MA
EDWARD J. HUTH
Philadelphia, PA

12:00

LUNCHEON
GEORGIA HEALTH SCIENCES LIBRARY ASSOCIATION

This program is sponsored by the Georgia Chapter of the American College of Physicians and the Georgia Health Sciences Library Association.

This program has been partially funded through a contribution from Merck, Sharp & Dohme.

Program is acceptable for Category 1 credit on an hour-for-hour basis for the AMA's Physician's Recognition Award.

CONFERENCE ON MEDICAL EDUCATION

Philosophies and Priorities of Medical Education in Georgia

Program Chairman

LOIS T. ELLISON, Provost, Medical College af Geargia, Augusta, GA; Chairman, MAG Subcammittee an Medical Schools.

Thursday, November 15, 1:30 p.m.

A jaint effart af the Medical Association af Geargia and the medical schools in Geargia, the conference is designed to

bring together representatives of the academic and private sectors of medicine to exchange ideas about medical education and the ways in which it affects the practicing community. All Scientific Assembly attendees, spouses, and guests are invited to attend.

1:30-3:00

DEANS' REPORTS

EMORY UNIVERSITY SCHOOL OF MEDICINE
New dean (to be announced)
MEDICAL COLLEGE OF GEORGIA
Fairfield Goodale
MERCER UNIVERSITY SCHOOL OF MEDICINE
John D. Harries
SCHOOL OF MEDICINE AT MOREHOUSE COLLEGE
Louis W. Sullivan

3:00-3:15

GOALS AND PRIORITIES OF THE MAG

EARNEST C. ATKINS
President

3:15-3:30

QUESTIONS AND ANSWERS

OPEN DISCUSSION

INTERMISSION

3:45-4:30

BREAKOUT GROUP DISCUSSIONS

4:30-5:00

REPORTS OF BREAKOUT GROUPS

7:30

MANAGEMENT OF HEMANGIOMAS OF THE TONGUE WITH CRYO-SURGERY

D. MORTON BOYETTE, M.D.
Albany

8:00

TOTAL FACIAL ANALYSIS WITH RESPECT TO PREOPERATIVE RHINOPLASTIC ANALYSIS

WILLIAM E. SILVER, M.D.
Atlanta

Sponsored by the Greater Atlanta Ear, Nose, and Throat Society

Program is acceptable for Category 1 credit on an hour-for-hour basis for the AMA's Physician's Recognition Award.

ALLERGY

Allergy and Immunology Society of Georgia

Program Chairman
DAVID G. TINKELMAN, Atlanta, GA

Guest Speakers
S. ALLAN BOCK, Assistant Professor of Pediatrics, University of Colorado Medical Center; Senior Staff Physician, National Jewish Hospital and Reseach Center, Denver, CO
RICHARD D. DESWARTE, Clinical Associate Professor of Medicine and Chief of Allergy Clinic, Northwestern University Medical Center; Medical Director, Rockford Clinic, Chicago, IL

Friday, November 16, 9:00 a.m.

Presiding:
David G. Tinkelman
Atlanta Allergy Clinic, P.A.
Atlanta, GA

9:00-10:00

DRUG ALLERGY

RICHARD D. DESWARTE
Guest Speaker
Chicago, IL

Dr. DeSwarte will discuss adverse drug reactions with emphasis on the evaluation and management of patients with suspected drug allergy.

INTERMISSION

10:30-11:30

FOOD ALLERGY

S. ALLAN BOCK
Guest Speaker
Denver, CO

Dr. Bock will discuss a practical approach to clinical management of food sensitivity.

11:30-12:00

BUSINESS MEETING

ALLERGY AND IMMUNOLOGY SOCIETY OF GEORGIA

12:00 **LUNCHEON**

ALLERGY AND IMMUNOLOGY SOCIETY OF GEORGIA

Sponsored by

Key Pharmaceuticals, Inc.

Program is acceptable for Category 1 credit on an hour-for-hour basis for the AMA's Physician's Recognition Award.

Program is acceptable for 2 Prescribed hours by the American Academy of Family Physicians.

Program is acceptable for 2 Category 1 credit hours by the American College of Emergency Physicians.

CHEST DISEASE

Georgia Thoracic Society

Program Chairman
C. NEIL KELLEY, Gainesville, GA

Guest Speakers
EDWARD A. GAENSLER, Professor of Surgery and Physiology, Boston University School of Medicine, Boston, MA
KAYE H. KILBURN, Mt. Sinai School of Medicine, New York, NY
W. KEITH MORGAN, University Hospital, London, Ontario

Friday, November 16, 8:30 a.m.

ENVIRONMENTAL LUNG DISEASE

Presiding:
C. Neil Kelley
Northeast Georgia Diagnostic Clinic
Gainesville, GA

8:30-9:15

ENVIRONMENTAL LUNG DISEASE — HOW COMMON AND HOW TO EVALUATE

EDWARD A. GAENSLER
Guest Speaker
Boston, MA

9:15-9:30

QUESTIONS

9:30-10:10

SMOKING — HOW IT AFFECTS ENVIRONMENTAL LUNG PROBLEMS

KAYE H. KILBURN
Guest Speaker
New York, NY

10:10-10:20

QUESTIONS

INTERMISSION

10:30-11:15

THE WORK PLACE — FACTORS WHICH INFLUENCE THE DEVELOPMENT OF ENVIRONMENTAL LUNG DISEASE

W. KEITH MORGAN
Guest Speaker
London, Ontario

11:15-11:30

QUESTIONS

11:30

LUNCHEON AND BUSINESS MEETING
GEORGIA THORACIC SOCIETY

Friday, November 16, 1:00 p.m.

Presiding:
Alan Plummer
President, Georgia Thoracic Society
Atlanta, GA

1:00-1:50

ASBESTOS RELATED DISEASES — A REVIEW

EDWARD A. GAENSLER
Guest Speaker
Boston, MA

1:50-2:00

QUESTIONS

2:00-2:45

COTTON DUST EXPOSURE AND THE LUNG — A REVIEW

KAYE H. KILBURN
Guest Speaker
New York, NY

2:45-2:55

QUESTIONS

INTERMISSION

3:00-3:45

SILICA AND THE LUNG — A REVIEW

W. KEITH MORGAN
Guest Speaker
London, Ontario

3:45-4:00

QUESTIONS

Saturday, November 17, 9:00 a.m.

Presiding:
Roland S. Summers
Professional Education Committee
Georgia Thoracic Society
Savannah, GA

9:00-9:45

COAL MINERS' RESPIRATORY DISEASE — THE RATIONAL AND IRRATIONAL IN DISABILITY CRITERIA

W. KEITH MORGAN
Guest Speaker
London, Ontario

9:45-10:20

SCREENING PROCEDURES TO DETECT OCCUPATIONAL LUNG PROBLEMS — HOW HELPFUL, WHAT KIND?

EDWARD A. GAENSLER
Guest Speaker
Boston, MA

10:20-11:00

DISABILITY DETERMINATION — ADVICE TO PHYSICIANS WHO MUST ASSIST THE LEGAL PROCESS

KAYE H. KILBURN
Guest Speaker
New York, NY

11:00-12:00

PANEL DISCUSSION

Panel:
EDWARD A. GAENSLER
Boston, MA
KAYE H. KILBURN
New York, NY
W. KEITH MORGAN
London, Ontario

This program has been partially funded through contributions from the Schering Corporation, the Georgia Marble Company, and Wyeth Laboratories.

Program is acceptable for Category 1 credit on an hour-for-hour basis for the AMA's Physician's Recognition Award.

Program is acceptable for 8.5 Prescribed hours by the American Academy of Family Physicians.

EMERGENCY MEDICINE

eorgia Chapter, American College of Emergency Physicians

m Chairman:
/T W. CRUMP, Royston, GA

Saturday, November 17, 1:00 p.m.

POISON CONTROL

ing:
t W. Crump
b Memorial Hospital
ston, GA

:00

NOUS PLANTS OF THIS AREA

ALBERT P. RAUBER
Atlanta, GA

gh presentation of slides and cataloguing poisonous by their mode of pharmacologic action, attending ians will learn to identify most toxic plants and be able cribe their effects and what treatment is indicated.

:00

OISON CONTROL CENTER

LESTER M. HADDAD
Savannah, GA

ncept of the poison control center — why, where, how, taffs, how information is compiled — is detailed.

sants:

ERGENCY MEDICAL RESIDENTS
dy MemorialHospital/Emory University

INTERMISSION

4:15

DEVELOPMENTS IN COMMON AND NOT SO COMMON ONINGS

LESTER M. HADDAD
Savannah, GA

of new breakthroughs and experimental protocols of lt poisoning problems will be discussed in a timely e of this area.

4:45

TH FOOD PLANT DERIVATIVES THAT ARE POISONOUS

LEE SCHRAM, Ph.D.
Department of Pharmacology
University of Georgia
Athens, GA

nt fad foods often offer more hazard than health. Herbs, and other concoctions sold in health food stores are sed with special emphasis on their pharmacologic of action.

am is acceptable for Category 1 credit on an hour-for-basis for the AMA's Physician's Recognition Award.

Program is acceptable for 3.5 Prescribed hours by the American Academy of Family Physicians.

Program is acceptable for 4 Category 1 credit hours by the American College of Emergency Physicians.

GASTROENTEROLOGY

Georgia Gastroenterologic Society

Program Chairman
ZACHARY M. KILPATRICK, Augusta, GA

Guest Speaker
HOWARD M. SPIRO, Professor of Medicine and Chief of Gastroenterology, Yale University School of Medicine, New Haven, CT

Friday, November 16, 10:20 a.m.

INFLAMMATORY BOWEL DISEASE

A Joint Meeting of the
Georgia Gastroenterologic Society
Georgia Radiologic Society
Georgia Chapter, American College of Surgeons

Presiding:
Zachary M. Kilpatrick
Associate Professor of Medicine
Medical College of Georgia
Augusta, GA

10:20-10:50

RADIOLOGIC ASPECTS OF INFLAMMATORY BOWEL DISEASE

WILLIAM M. THOMPSON
Guest Speaker
Associate Professor of Radiology
Duke Medical Center
Durham, NC

X-ray diagnosis is often key in the medical and surgical treatment of patients with inflammatory bowel disease. The available techniques and the findings in selected cases will be presented.

10:50-11:10

WHAT'S NEW IN THE DIAGNOSIS AND THERAPY OF INFLAMMATORY BOWEL DISEASE?

HOWARD M. SPIRO
Guest Speaker
New Haven, CT

Greater numbers of patients than ever before are being seen with inflammatory bowel disease. The current view of etiology and medical approach to diagnosis and therapy will be discussed.

11:10-11:30

THE ROLE OF SURGERY IN INFLAMMATORY BOWEL DISEASE

MARION C. ANDERSON
Guest Speaker
Professor and Chairman
Department of Surgery
Medical University of South Carolina
Charleston, SC

Surgical procedures are employed to correct the complications which develop in the course of inflammatory bowel

disease. Although an operation may be required to induce a remission, the disease is not cured by surgical ablation. Alternative surgical approaches will be described.

11:30-12:00

PANEL DISCUSSION AND AUDIENCE PARTICIPATION

Panel:
WILLIAM M. THOMPSON
Durham, NC
HOWARD M. SPIRO
New Haven, CT
MARION C. ANDERSON
Charleston, SC
WILLIAM C. MCGARITY
Atlanta, GA
JOSEPH W. GRIFFIN
Augusta, GA

LUNCHEON AND BUSINESS MEETING

GEORGIA CHAPTER, AMERICAN COLLEGE OF SURGEONS

LUNCHEON

GEORGIA SOCIETY OF INTERNAL MEDICINE

See information under Internal Medicine

Friday, November 16, 1:30 p.m.

BENIGN DISEASE OF THE AMPULLA, PANCREAS, AND DISTAL BILE DUCT

A Joint Meeting of the
Georgia Gastroenterologic Society
Georgia Radiological Society
Georgia Chapter, American College of Surgeons

Presiding:
Eugene D. Davidson
Assistant Professor of Surgery
Emory University School of Medicine
Atlanta, GA

1:30-2:00

PSEUDOCYSTS OF THE PANCREAS INVOLVING THE DUCT OF SANTORINI

MARION C. ANDERSON
Guest Speaker
Charleston, SC

A series of 14 patients with pseudocyst involving the superior aspect of the head of the pancreas will be reviewed. In most cases the cyst could be visualized radiographically by transduodenal cannulation of the duct of Santorini. These cysts do not communicate with the duct of Wirsung and may be overlooked in performing retrograde drainage procedures such as longitudinal pancreaticojejunostomy.

2:00-2:30

RADIOLOGIC APPROACH TO THE BILIARY TREE

WILLIAM M. THOMPSON
Guest Speaker
Durham, NC

Recent advances in radiologic technique including ultrasound computerized scanning, as well as contrast injection studies, have allowed more precise diagnosis of the biliary tree, sphincter of Oddi, and pancreatic duct in various disease states. The use of these different modalities and their indications will be discussed.

2:30-3:00

THE GASTROENTEROLOGIST LOOKS AT THE SPHINCTER OF ODDI

HOWARD M. SPIRO
Guest Speaker
New Haven, CT

Various disorders of the biliary and pancreatic systems center on the ampulla and the sphincter of Oddi. Sphincteric function and its role in the production of disease states such as postcholecystectomy syndrome will be presented.

3:00-3:45

PANEL DISCUSSION ON BENIGN DISEASES OF THE PANCREAS, AMPULLA, AND DISTAL BILE DUCT

Panel:

WILLIAM M. THOMPSON
Durham, NC
HOWARD M. SPIRO
New Haven, CT
MARION C. ANDERSON
Charleston, SC
E. L. BRADLEY III
Atlanta, GA
FRANCIS J. TEDESCO
Augusta, GA

Program is acceptable for Category 1 credit on an hour-for-hour basis for the AMA's Physician's Recognition Award.

Program is acceptable for 4 Prescribed hours by the American Academy of Family Physicians.

INTERNAL MEDICINE

Georgia Chapter, American College of Physicians

Program Chairman
J. WILLIS HURST, Atlanta, GA

Arrangements Chairman
WILLIAM C. WATERS III, Atlanta, GA

Friday, November 16, 8:30 a.m.

8:30-9:15

CORONARY BYPASS SURGERY

J. WILLIS HURST
Professor of Medicine (Cardiology)
Chairman of the Department of Medicine
Emory University School of Medicine
Atlanta, GA

9:15-10:00

HEPATITIS UPDATE—1979

JOHN T. GALAMBOS
Professor of Medicine (Digestive Diseases)
Emory University School of Medicine
Atlanta, Ga

INTERMISSION

10:30-11:15

RECENT ADVANCES IN THE TREATMENT OF HYPERTENSION

W. DALLAS HALL JR.
Professar af Medicine (Hypertension)
Emary University School of Medicine
Atlanta, GA

11:15-12:00

THE AMERICAN COLLEGE OF PHYSICIANS—1979

Representative fram the
American College af Physicians

12:00

LUNCHEON

GEORGIA SOCIETY OF INTERNAL MEDICINE

"Medical Policies and Goals of the Administration"

MR. JOSEPH N. ONEK
Associate Directar far the Damestic Palicy Staff
The White House
Washington, DC

Mr. Onek was graduated from the Yale Law Schaal in 1967 and has had a distinguished career as an attarney warking with the formulation of policy. He was Adjunct Prafessar af Health Care Law at the University af Maryland Law Schaal and Director of the Center far Law and Sacial Palicy. Immediately prior to his present position on the White House staff, he was Directar af Health Palicy Analysis for the Carter-Mondale Transitian Planning Group. In 1977 he prepared a study "Public Participation in the Policy Formulation Pracess" for the Advisory Committee on National Growth Palicy Processes to the National Commission on Supplies and Shartages.

All members, spouses, and guests are invited to attend.

Friday, November 16, 1:30 p.m.

1:30-2:15

NEW ADVANCES IN ENDOCRINOLOGY

JAMES H. CHRISTY
Professor af Medicine (Endacrinology)
Emary University School of Medicine
Atlanta, GA

2:15-3:00

NEW ANTIBIOTICS

JONAS A. SHULMAN
Prafessor of Medicine (Infectious Diseases)
Emory University Schaal af Medicine
Atlanta, GA

3:00-3:45

THE MEDICAL TREATMENT OF GALLSTONES

THEODORE HERSH
Prafessor of Medicine (Digestive Diseases)
Emary University Schaal af Medicine
Atlanta, GA

Saturday, November 17, 8:30 a.m.

8:30-9:15

STROKES, LANGUAGE, AND ARCHITECTURE

H. KENNETH WALKER
Assaciate Prafessor of Medicine
Emary University Schaal of Medicine
Atlanta, GA

9:15-10:00

DRUG THERAPY AND SOLID TUMORS: CURRENT STATUS

R. MARTIN YORK
Assistant Professor af Medicine (Hematology)
Emary University Schaal af Medicine
Atlanta, GA

INTERMISSION

10:30-11:15

ADVANCES IN THE TREATMENT OF RHEUMATOID ARTHRITIS

C. H. WILSON JR.
Prafessor of Medicine (Rheumatolagy)
Emory University School of Medicine
Atlanta, GA

11:15-12:00

NEW CONCEPTS IN ACID-BASE BALANCE

RONALD L. MARS
Assistant Professor af Medicine (Nephralogy)
Emory University School af Medicine
Atlanta, GA

Program is acceptable for Category 1 credit on an hour-for-hour basis for the AMA's Physician's Recognition Award.

NEUROLOGY

Georgia Neurological Society

Program Chairman
ROBERT W. GILBERT JR., Atlanta, GA

Guest Speaker

MARCUS E. RAICHLE, Department of Neurology, Washington University Schaal of Medicine, St. Lauis, MO

Saturday, November 17, 9:00 a.m.

MANAGEMENT OF CEREBROVASCULAR DISEASE

A Joint Meeting of the
Georgia Neurological Society
Georgia Neurosurgical Society

Presiding:
Robert W. Gilbert Jr.
Atlanta Neuralagical Clinic
Atlanta, GA

9:00-9:15

MEDICAL MANAGEMENT OF CEREBROVASCULAR DISEASE

HERBERT R. KARP
Chairman and Prafessar
Department af Neuralogy
Emary University School of Medicine
Atlanta, GA

An overview af recent develapments in medical management af cerebravascular disease, including antiplatelet drugs. The Canadian study af aspirin and Persantine will be reviewed. Discussion af nan-invasive diagnostic tests far cerebrovascular disease, including Doppler scanning, aculoplethysmography, and other madalities will be made.

9:15-9:35

NEURO-RADIOLOGIC EVALUATION OF CEREBROVASCULAR DISEASE

WILLIAM E. MILLER
Savannah, GA

The neuro-radialogic evaluation af vascular disease will be reviewed with special emphasis on angiagraphy and specialized techniques therein. This includes discussian af 105 mm. spot filming of lesions in questian and multiple projection magnification angiography with high resolution filming for detailed analysis of intracranial vascular lesians. The complicatians of angiography and techniques in their preventian will also be emphasized.

9:35-10:20

CEREBRAL BLOOD FLOW AND CEREBRAL METABOLISM IN CEREBROVASCULAR DISEASE

MARCUS E. RAICHLE
Guest Speaker
St. Lauis, MO

Review of the basic principles of cerebral bload flaw study, using canventianal Xenon techniques and newer Positron emitting techniques as well as cerebral metabalism analysis, utilizing metabolically active radioactive campounds. The application of these techniques ta the analysis of cerebral blaad flaw in vascular disease to be emphasized. Their application, clinically, will be discussed particularly as relates to extracranial-intracranial bypass.

INTERMISSION

10:40-11:25

INTRACRANIAL-EXTRACRANIAL BYPASS PROCEDURES — INDICATIONS, RESULTS, AND TECHNICAL CONSIDERATIONS

SIDNEY J. PEERLESS
Guest Speaker
Department of Neurasurgery
University af Western Ontario
London, Ontaria

The current pragress af the International Combined Study for Extracranial-Intracranial Anastomasis will be reviewed with discussion af the progress of the study and emphasis upan thase cases which qualify. Indicatians far cerebral bypass pracedures as currently understaad will be emphasized, and technical considerations will be discussed in same detail. Results af bypass procedures as currently understaod will be discussed.

11:25-11:35

EXTRACRANIAL VASCULAR DISEASE — SURGICAL RESULTS AND THE DILEMMA OF ENDARTERECTOMY VS. BYPASS IN SELECTED CASES

FREMONT P. WIRTH
Savannah, GA

A brief discussion of the indications and results af carotid endarterectomy will be presented. This procedure will then be discussed in comparisan with the bypass with the presentation of selective cases which pravide a challenge in terms af decision regarding bypass vs. endarterectomy.

11:35-12:00

PANEL DISCUSSION

Program is acceptable for Category 1 credit on an hour-for-hour basis for the AMA's Physician's Recognition Award.

Program is acceptable for 2.5 Prescribed hours by the American Academy of Family Physicians.

Program is acceptable for 3 Category 1 credit hours by the American College of Emergency Physicians.

12:00

RECEPTION

GEORGIA NEUROLOGICAL SOCIETY

GEORGIA NEUROSURGICAL SOCIETY

12:45

LUNCHEON

GEORGIA NEUROLOGICAL SOCIETY

Saturday, November 17, 2:00 p.m.

2:00-3:00

PANEL DISCUSSION WITH GUEST SPEAKER

Panel:
MARCUS E. RAICHLE
St. Louis, MO

Program is acceptable for Category 1 credit on an hour-for-hour basis for the AMA's Physician's Recognition Award.

NEUROSURGERY

Georgia Neurosurgical Society

Program Chairman
FREMONT P. WIRTH, Savannah, GA

Guest Speaker
SIDNEY J. PEERLESS, Department of Neurasurgery, University of Western Ontaria, London, Ontaria

Saturday, November 17, 9:00 a.m.

MANAGEMENT OF CEREBROVASCULAR DISEASE

A Joint Meeting of the
Georgia Neurological Society
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See pragram under Neuralagy

12:00

RECEPTION

GEORGIA NEUROLOGICAL SOCIETY

GEORGIA NEUROSURGICAL SOCIETY

12:45

LUNCHEON AND BUSINESS MEETING

GEORGIA NEUROSURGICAL SOCIETY

Saturday, November 17, 2:00 p.m.

2:00-4:00

PROBLEM CASES IN INTRACRANIAL VASCULAR DISEASE, ANEURYSMS, ARTERIOVENOUS MALFORMATIONS, ETC.

SIDNEY J. PEERLESS
Guest Speaker
London, Ontario

Program is acceptable for Category 1 credit on an hour-for-hour basis for the AMA's Physician's Recognition Award.

OPHTHALMOLOGY

Georgia Society of Ophthalmology

Program Chairman
WILLIAM H. JARRETT II, Atlanta, GA

Guest Speaker
A. E. MAUMENEE, William Holland Wilmer Professor of Ophthalmology, Department of Ophthalmology, Johns Hopkins School of Medicine, Baltimore, MD

Saturday, November 17, 8:30 a.m.

8:30-8:40

WELCOME

THOMAS H. SMITH JR.
President
Georgia Society of Ophthalmology
Valdosta, GA

8:40-8:50

RESECTION AND RECONSTRUCTION OF THE LOWER CANALICULUS

CLINTON D. MCCORD JR.
Atlanta, GA

8:50-9:00

EVALUATION AND MANAGEMENT OF OBSTRUCTION OF THE NASOLACRIMAL DRAINAGE SYSTEM

MALCOLM N. LUXENBERG
Augusta, GA

9:00-9:10

CRYOSURGERY FOR BASAL CELL CARCINOMA OF THE EYELID

HOWARD L. BRUCKNER
Augusta, GA

9:10-9:20

DISCUSSION OF PRECEDING PAPERS

9:20-9:30

THE ROLE OF ULTRAVIOLET LIGHT IN LENS AGING AND CATARACTOGENESIS

SIDNEY LERMAN
Atlanta, GA

9:30-9:40

A COMPARISON OF PLANNED EXTRACAPSULAR CATARACT EXTRACTIONS TO INTRACAPSULAR CATARACT EXTRACTIONS IN A RESIDENT POPULATION

STEVE MCQUAIG
Augusta, GA

9:40-9:50

LOOP POSITION OF THE SHEARING POSTERIOR CHAMBER LENS

BARRIE H. THRASHER
Atlanta, GA

9:50-10:00

THE POSTERIOR CHAMBER INTRAOCULAR LENS — A SECOND LOOK

JESS C. LESTER
Atlanta, GA

10:00-10:10

DISCUSSION OF PRECEDING PAPERS

10:10-10:40

OPHTHALMOLOGY: PAST, PRESENT, AND FUTURE

A. E. MAUMENEE
Guest Speaker
Baltimore, MD

INTERMISSION

11:00-11:10

VITREOUS PATHOLOGY IN BECHET'S DISEASE

BRUCE H. BECKER
Atlanta, GA

11:10-11:20

CHANGES IN CORNEAL THICKNESS AFTER SCLERAL BUCKLING SURGERY

EDWARD FINEBERG
Augusta, GA

11:20-11:30

MALIGNANT MELANOMA IN AN EYE WITH INTRAOCULAR LENS

EDWIN H. DONNELLY and WILLIAM H. JARRETT II
Atlanta, GA

11:30-11:40

MASSIVE INTRAOCULAR HEMORRHAGE COMPLICATING SMD

WILLIAM H. JARRETT II, and THOMAS S. HARBIN JR.
Atlanta, GA
MEIMEI CHANG
China

11:40-11:50

PARS PLANA VITRECTOMY WITH OCUTOME SYSTEM

WILLIAM S. HAGLER
Atlanta, GA

11:50-12:00

VITRECTOMY FOR ANTERIOR SEGMENT IN PEDIATRIC OPHTHALMOLOGY

ZANE F. POLLARD
Atlanta, GA

12:00-12:10

MECHANICAL VITRECTOMY IN 100 ANTERIOR SEGMENT SURGICAL CASES: A SYSTEMATIC APPROACH

GEORGE O. WARING
Atlanta, GA

12:10-12:20

VITRECTOMY FOR DIABETIC TRACTION RETINAL DETACHMENT

H. J. KAPLAN
Atlanta, GA
T. M. AABERG
Milwaukee, WI

12:20-12:30

DISCUSSION OF PRECEDING PAPERS

12:30

LUNCHEON

GEORGIA SOCIETY OF OPHTHALMOLOGY

Saturday, November 17, 2:00 p.m.

2:00-2:10

VITRECTOMY AND FILTER FOR APHAKIC GLAUCOMA

FRANK C. BELL and DAVID G. CAMPBELL
Atlanta, GA

2:10-2:20

TRABECULECTOMY

THOMAS S. HARBIN JR.
Atlanta, GA

2:20-2:30

DPE IN THE THERAPY OF GLAUCOMA

JOHN F. BIGGER
Augusta, GA

2:30-2:40

THE SPECTRUM OF ESSENTIAL IRIS ATROPHY: A NEW THEORY OF PATHOPHYSIOLOGY

DAVID G. CAMPBELL
Atlanta, GA

2:40-2:50

MANAGEMENT OF CICATRIZING CONJUNCTIVITIS ASSOCIATED WITH OCULAR PEMPHIGOID

LOUIS A. WILSON
Atlanta, GA

2:50-3:00

ELECTROPHYSIOLOGY OF THE EYE AND STRABISMOLOGY

ALVIN W. NORTH
Atlanta, GA

3:00-3:40

CORNEAL SURGERY: AN OVERVIEW

A. E. MAUMENEE
Guest Speaker
Baltimore, MD

INTERMISSION

4:00-4:10

MANAGEMENT OF CORNEAL EDEMA

DAVID S. HULL
Augusta, GA

4:10-4:20

MOOREN'S CORNEAL ULCER

MIKE PATIPA
Augusta, GA

4:20-4:30

NON-CONTACT SPECULAR MICROSCOPY OF THE CORNEAL ENDOTHELIUM

BERNARD E. MCCRARY
Atlanta, GA

4:30-4:40

BILATERAL KERATOPLASTY IN KERATOCONUS — DO SECOND GRAFTS INCREASE THE CHANCE OF REJECTION?

H. DWIGHT CAVANAGH
Atlanta, GA

4:40-4:50

POTENTIAL OCULAR COMPLICATIONS OF PSORALEN THERAPY AND THEIR PREVENTION

SIDNEY LERMAN
Atlanta, GA

4:50-5:00

DISCUSSION OF PRECEDING PAPERS

Program is acceptable for Category 1 credit on an hour-for-hour basis for the AMA's Physician's Recognition Award.

Program is acceptable for 6.5 Elective hours by the American Academy of Family Physicians.

PATHOLOGY

Georgia Association of Pathologists

Atlanta Society of Pathologists

Program Chairmen
F. NORMAN BOWLES JR., Austell, GA
JACQUELINE H. WERNER, Riverdole, GA

Guest Speakers
WILLIAM J. CATALONA, Deportment of Urology, Washington University School of Medicine, St. Louis, MO
JULIO CORTES, Director, Interlab Associotes Inc., Miomi, FL
F. K. MOSTOFI, Chief, Genitourinory Pothology Bronch, Armed Forces Institute of Pathology, Woshington, DC

Saturday, November 17, 9:00 a.m.

Presiding:
F. Norman Bowles Jr.
Cobb General Hospitol
Austell, GA

9:00-10:30

MANAGEMENT OF TUMORS OF THE BLADDER, PROSTATE, KIDNEY, AND TESTES

WILLIAM J. CATALONA
Guest Speoker
St. Louis, MO

INTERMISSION

10:45-12:15

(Dr. Cotolono will continue his presentotion of the obove subject)

Saturday, November 17, 2:00 p.m.

2:00-3:30

PANEL DISCUSSION

TUMOR MARKERS IN TUMORS OF THE GU TRACT

Moderator:
Julio Cortes, Director
Interlab Associotes Inc.
Miomi, FL

INTERMISSION

3:45-5:15

(Dr. Cortes will continue the ponel discussion of the obove)

Sunday, November 18, 9:00 a.m.-4:30 p.m.

LESIONS OF THE MALE GENITOURINARY TRACT

ANNUAL SLIDE SEMINAR

ATLANTA SOCIETY OF PATHOLOGISTS

Moderator:
Jocqueline H. Werner
Cloyton General Hospitol
Riverdole, GA

Discussant:
F. K. MOSTOFI
Woshington, DC

Discussion will center around specific coses submitted by locol pothologists ond Dr. Mostofi, incorporoted into slide sets prepored for purchase before the seminor. Lesions of the testis, prostote, blodder, ond kidney ore included. Clinicol histories on oll coses occompony the slide sets.

Program is acceptable for Category 1 credit on an hour-for-hour basis for the AMA's Physician's Recognition Award.

PEDIATRICS

Georgia Chapter, American Academy of Pediatrics

Program Chairman:
JOSEPH H. PATTERSON, Atlonto, GA

Guest Speakers
A. DAVID BRANDLING-BENNETT, Chief, Surveillonce and Assessment Bronch, Immunizotion Division, Bureau of State Services, Center for Diseose Control, Atlonto, GA
CLAIRE V. BROOME, Speciol Pothogens Bronch, Bacteriol Diseoses Division, Bureau of Epidemiology, Center for Diseose Control, Atlanta, GA
ALAN R. HINMAN, Director, Immunizotion Division, Bureou of Stote Services, Center for Diseose Control, Atlonto, GA

Friday, November 16, 1:30 p.m.

UPDATE ON IMMUNIZATIONS

1:30-2:10

PRESENT STATUS OF MEASLES AND RUBELLA VACCINATION

A. DAVID BRANDLING-BENNETT
Guest Speaker
Atlonto, GA

The mojority of meosles and rubella cases in the United Stotes ore now occurring omong odolescents and young odults. Immunizotion levels in these age groups remain low in spite of recommendotions thot persons lacking a physicion-confirmed history of disease or documented history of immunizotion receive measles and rubella vaccines. In spite of the potentiol threat to pregnoncy, the risks of disease outweigh the risks of vaccination.

2:10-2:50

BACTERIAL IMMUNIZATIONS

CLAIRE V. BROOME
Guest Speoker
Atlonto, GA

Recent evidence on the odverse reaction rotes to pertussis voccinotion will be discussed and compored to the expected benefits of voccinotion. Indications for meningococcal voccine will be reviewed. The first yeor's experience following the licensing of the pneumococcal polysocchoride vaccine will be summorized, including informotion on adverse reoc-

tions observed. The current status of the develapment af a satisfactory vaccine against *Haemophilus influenzae* will be presented.

INTERMISSION

3:00-3:40

PROBLEMS OF LIABILITY AND CONSENT IN IMMUNIZATION — PUBLIC AND PRIVATE SECTORS

ALAN R. HINMAN
Guest Speaker
Atlanta, GA

There are three major aspects to the problem of liability related to vaccines: the manufacturer's liability, the liability of the health-care provider, and compensatian far the person injured by vaccination. The primary cancerns abaut manufacturer's liability have centered on the obligatian ta warn the vaccine recipient af the risks as well as the benefits of vaccination. This has primarily affected vaccines delivered in the public sector. To carry out this "duty to warn," a series of information farms has been develaped for use in public clinics to try to ensure that the vaccine recipient understands the benefits and risks af vaccination and gives an informed consent. Recent court decisions suggest that similar approaches may be required in the private sector as well.

3:40-4:00

PANEL DISCUSSION WITH THE AUDIENCE
Panel:

A. DAVID BRANDLING-BENNETT
Atlanta, GA
CLAIRE V. BROOME
Atlanta, GA
ALAN R. HINMAN
Atlanta, GA

Program is acceptable for Category 1 credit on an hour-for-hour basis for the AMA's Physician's Recognition Award.

Program is acceptable for 2.5 Prescribed hours by the American Academy of Family Physicians.

PLASTIC SURGERY

Georgia Society of Plastic Surgeons

Program Chairman
E. ANTHONY MUSARRA II, Marietta

Friday, November 16, 9:00 a.m.

Presiding:
E. Anthany Musarra II
Kennestone Haspital
Marietta, GA

9:00-9:20

DEFORMING CONGENITAL DEFECTS — GENERAL CONSIDERATIONS FOR PEDIATRICIANS

WILLIAM HUGER JR
Atlanta, GA

General considerations for pediatricians in caunselling parents and seeking plastic surgical consultation will be presented.

9:20-9:40

CONGENITAL DEFECTS — GENERAL CONSIDERATIONS FOR PLASTIC SURGEONS

PAUL W. BLACK
Atlanta, GA

General cansiderations for counselling parents and planning treatment for congenital defects will be autlined.

9:40-9:55

CLEFT LIP

CARL R. HARTRAMPF JR.
Atlanta, GA

9:55-10:10

CLEFT PALATE

JOHN M. GRIFFIN
Atlanta, GA

10:10-10:25

CRANIAL FACIAL ANOMALIES

FOAD NAHAI
Atlanta, GA

INTERMISSION

10:45-11:00

CONGENITAL DEFORMITIES OF THE EXTERNAL EAR

LOVIC W. HOBBY
Atlanta, Ga

11:00-11:15

CONGENITAL EYELID PTOSIS

DIANNE C. LEEB
Tucker, GA

11:15-11:30

CONGENITAL DEFORMITIES OF THE HAND

KENNA S. GIVEN
Augusta, GA

11:30-11:45

CONGENITAL DEFORMITIES OF THE GENITO-URINARY TRACT

THEODORE C. WHITSON
Decatur, GA

11:45-12:00

HEMANGIOMA

JOHN BOSTWICK III
Atlanta, GA

Program is acceptable for Category 1 credit on an hour-for-hour basis for the AMA's Physician's Recognition Award.

Program is acceptable for 3 Prescribed hours by the American Academy of Family Physicians.

PSYCHIATRY

Georgia Psychiatric Association

Program Chairman
DAVID M. NICHOLS, Atlanta, GA

Guest Speaker
EMANUEL TANAY, Clinicol Professor of Psychiatry, Woyne Stote University, Detroit, MI

Saturday, November 17, 9:00 a.m.

9:00-10:15

VIOLENCE AND MEDICINE

EMANUEL TANAY
Guest Speoker
Detroit, MI

A discussion of various forms of violence likely to be encountered by procticing physicians. Porticular emphasis will be ploced upon introfomiliol violence ond the role of physicions in prevention.

INTERMISSION

10:30-12:00

LEGAL ASPECTS OF MEDICAL PRACTICE

EMANUEL TANAY
Guest Speoker
Detroit, MI

A discussion of legol obligotions of physicions in relation to potients. Informed consent, right to refuse treotment, ond other concepts will be discussed.

Saturday, November 17, 2:00 p.m.

1:30-3:00

PSYCHIC TRAUMA AND MEDICINE

EMANUEL TANAY
Guest Speoker
Detroit, MI

A discussion of emotional complicotions ossocioted with physicol injury and illness. Clinicol illustrotions will be provided.

Program is acceptable for Category 1 credit on an hour-for-hour basis for the AMA's Physician's Recognition Award.

Program is acceptable for 4.5 Prescribed hours by the American Academy of Family Physicians.

Program is acceptable for 5 Category 1 credit hours by the American College of Emergency Physicians.

PUBLIC HEALTH

Georgia Chapter, American Association of Public Health Physicians

Program Chairman
GUNAR N. BOHAN, Decotur, GA

Guest Speaker
J. DON MILLAR, Chief, Bureou of Stote Services, Notionol Center for Disease Control, Atlonto, GA

Friday, November 16, 9:00 a.m.

Presiding:
Williom R. Elseo
Commissioner of Heolth
Fulton County Heolth Deportment
Atlonto, GA

9:00-9:15

WELCOME AND INTRODUCTION

WILLIAM R. ELSEA
President
Georgio Chopter, Americon Associotion of Public Health Physicions

9:15-10:00

EMERGING CONCEPTS IN PREVENTIVE MEDICINE

J. DON MILLAR
Guest Speoker
Atlonto, GA

It is prevention, ond not curotive medicine, which has occounted for the substontiol reduction in diseose ond eorly deoth through the yeors.

A study of the major causes of deoth is the most significont ond convenient woy of determining today's mojor heolth problems; even more useful is a study of the causes of premature deoth. Anolyses of the 10 leoding couses of deoth in the United Stotes in 1976 show thot over holf of the mortality was due to lifestyle, 20% to environmentol factors, 20% to humon biological factors, ond only obout 10% to inodequocies in heolth core. These figures suggest thot we must reexomine our priorities for notionol heolth spending since, in 1978, only 0.8% of the federol heolth dollor wos invested in oltering unheolthy lifestyles, while 80% went toward remedying inodequocies in the heolth service delivery system.

HEW hos recently proposed o "Prevention Initiotive" for fiscal year 1980. It is not cleor whether on increosed commitment to prevention con olter present mortolity figures, since ottocking todoy's mojor couses of deoth is neither o simple nor cleor-cut tosk ond will require a much greater commitment on the port of the individual and community. However, there is no alternotive to the methods of prevention ond the prevention "system" of which we ore oll o port.

10:00-10:30

DISCUSSION

Program is acceptable for Category 1 credit on an hour-for-hour basis for the AMA's Physician's Recognition Award.

RADIOLOGY

Georgia Radiological Society

Program Chairman
STEWART R. ROBERTS JR., Atlanto, GA

Guest Speaker
WILLIAM M. THOMPSON, Associote Professor of Rodiology, Duke Medicol Center, Durhom, NC

Friday, November 16, 10:20 a.m.

INFLAMMATORY BOWEL DISEASE
BENIGN DISEASE OF THE AMPULLA, PANCREAS, AND DISTAL BILE DUCT

A Joint Meeting of the
Georgia Gastroenterologic Society
Georgia Radiological Society
Georgia Chapter, American College of Surgeons

See program under Gastroenterology

Saturday, November 17, 9:00 a.m.

Presiding:
Stewart R. Roberts Jr.
Associate Professor of Radiology
Emory University Hospital
Atlanta, GA

9:00-10:30

INFLAMMATORY DISEASES OF THE COLON: DIFFERENTIAL DIAGNOSTIC CONSIDERATIONS

WILLIAM M. THOMPSON
Guest Speaker
Durham, NC

This 1½ hour course was a refresher course presented at the American Roentgen Ray meeting in Toronto in 1979. Inflammatory bowel disease; diverticular disease; ischemic, pseudomembranous, and infectious colitis will be discussed. There will be a pre-course and post-course test. Handouts and references will be available.

INTERMISSION

10:50-11:20

THE RADIOGRAPHIC APPROACH TO INTRAABDOMINAL ABSCESSES

WILLIAM M. THOMPSON
Guest Speaker
Durham, NC

The intraabdominal abscess may be a diagnostic dilemma. The diagnostic tools available to the radiologist are multiple. The diagnosis of the intraabdominal abscess with particular emphasis on the pancreatic abscess is discussed.

11:20-12:30

BUSINESS MEETING

GEORGIA RADIOLOGICAL SOCIETY

Program is acceptable for Category 1 credit on an hour-for-hour basis for the AMA's Physician's Recognition Award.

Program is acceptable for 2 Prescribed hours by the American Academy of Family Physicians.

SURGERY

Georgia Chapter, American College of Surgeons

Program Chairman
EUGENE D. DAVIDSON, Atlanta, GA

Guest Speaker
MARION C. ANDERSON, Professor and Chairman, Department of Surgery, Medical University of South Carolina, Charleston, SC

Friday, November 16, 8:30 a.m.

Presiding:
Marion C. Anderson
Professor and Chairman
Department of Surgery
Medical University of South Carolina
Charleston, SC

8:30-8:40

RECONSTRUCTION OF THE ABDOMINAL WALL, GROIN, AND PERINEUM WITH MUSCLE AND MUSCULOCUTANEOUS FLAPS

FOAD NAHAI and T. RODERICK HESTER
Atlanta, GA
Presentation by Dr. Nahai

The anatomic basis and clinical application of muscular and myocutaneous flaps with application to reconstructive surgery of the abdominal wall, groin, and perineum will be discussed. Applications of tensor fascia lata and gracilis musculocutaneous units in reconstruction of the abdomen and perineum will be presented.

8:40-8:45

DISCUSSION

8:45-8:55

SURGICAL TREATMENT OF OBESITY

ROBERT H. VAUGHAN
Columbus, GA

100 patients will be presented who underwent jejunoileal or gastric bypasses for morbid obesity. The indications, complications, and technical aspects associated with these procedures will be reviewed.

8:55-9:00

DISCUSSION

9:00-9:10

CAROTID ARTERY ENDARTERECTOMY WITH CONTRALATERAL INTERNAL CAROTID ARTERY OCCLUSION (IS AN INTERNAL SHUNT NECESSARY?)

DOUGLASS G. WHITNEY, ERIC M. KAHN
JAMES W. ESTES, and CALVIN E. JONES
Atlanta, GA
Presentation by Dr. Whitney

The use of internal carotid artery shunts at the time of carotid endarterectomy is controversial. This series of patients supports the idea that such shunting is unnecessary, even in patients where the contralateral carotid artery is totally occluded. The importance of arterial occlusion time during carotid reconstructive surgery will be emphasized.

9:10-9:15

DISCUSSION

9:15-9:25

CURRENT OFFICE MANAGEMENT OF HEMORRHOIDS

M. FELTON HAGOOD
Marietta, GA

Proper management of symptomatic hemorrhoids is determined by the size and degree of prolapse of hemorrhoids. The use of medical management, sclerosing injections, ligation, dilatation, sphincterotomy, freezing, and surgery will be discussed. The current preferred methods for office management of hemorrhoids will be presented.

9:25-9:30

DISCUSSION

9:30-9:40

RECONSTRUCTION OF THE FEMALE BREAST FOLLOWING MASTECTOMY

JOHN R. LEWIS JR.
Atlanta, GA

Many methods have been recommended in reconstructing the female breast after mastectomy. A discussion of various reconstructive procedures with emphasis on maintenance of normal function and minimizing morbidity and loss of time from usual activity will be presented. Cases demonstrating various reconstructive procedures will be given.

9:40-9:45

DISCUSSION

9:45-9:55

ORBITAL DECOMPRESSION: ITS APPLICATION IN THE TREATMENT OF GRAVES' DISEASE AND OTHER CONDITIONS

CLINTON D. MCCORD
Atlanta, GA

The use of orbital decompression in patients with severe ophthalmic symptoms with Graves' disease and orbital lymphangiomas not responsive to other therapy will be presented. The technique will be discussed, and the improvement and preservation of visual function will be documented.

9:55-10:00

DISCUSSION

INTERMISSION

Friday, November 16, 10:20 a.m.

INFLAMMATORY BOWEL DISEASE
BENIGN DISEASE OF THE AMPULLA, PANCREAS, AND DISTAL BILE DUCT

A Joint Meeting of the
Georgia Gastroenterologic Society
Georgia Radiological Society
Georgia Chapter, American College of Surgeons

See program under Gastroenterology

12:00

LUNCHEON AND BUSINESS MEETING

GEORGIA CHAPTER, AMERICAN COLLEGE OF SURGEONS

Saturday, November 17, 9:00 a.m.

Presiding:
LaMar S. McGinnis Jr.
Clinical Associate Professor of Surgery
Emory University School of Medicine
Atlanta, GA

9:00-10:00

RESIDENT COMPETITION

FIBRONECTIN LEVELS IN TRAUMA: SERUM DEPLETION, WOUND SEQUESTRATION, BIOLOGICAL AND CLINICAL ACTIVITY

ANGELA ROBBINS
Augusta, GA

CORRELATION OF ULTRASOUND GALLBLADDER STUDIES WITH OPERATIVE FINDINGS

CHRIS DAVIS
Macon, GA

A PHARMACOKINETIC METHOD FOR MEASURING MAXIMAL RATE OF UREA SYNTHESIS

ERIC B. RYPINS
Atlanta, GA

CPA/OPG TESTING VERSUS ARTERIOGRAPHY — IS NONINVASIVE TESTING OF BENEFIT?

DAVID MCCLUSKY JR.
Atlanta, GA

Judges for this competition will be Drs. Marion C. Anderson, Charleston, SC; P. K. Dixon, Gainesville, GA; Charles G. Child III, Atlanta, GA; T. Gray Fountain, Albany, GA; Charles H. Watt Jr., Thomasville, GA; and Harold S. Engler, Augusta, GA.

PANCREATIC MALIGNANCIES

10:00-10:30

OBSTRUCTIVE JAUNDICE AND MALIGNANT PANCREATICODUODENAL DISEASE

MARION C. ANDERSON
Guest Speaker
Charleston, SC

The differentiation between benign and malignant jaundice can challenge the most experienced clinician. The utility of various modalities, including recent developments such as ERCP and CAT scanning, will be reviewed. Relationship of these to pancreatic and periampullary neoplasms will be discussed.

INTERMISSION

10:50-11:20

PANCREATICODUODENAL MALIGNANCIES — A LIFETIME EXPERIENCE

CHARLES G. CHILD III
Atlanta, GA

The approach and philosophy behind an extensive experience with pancreaticoduodenal malignancies will be reviewed. The results of surgical treatment will be presented.

11:20-12:00

PANEL DISCUSSION ON PANCREATICODUODENAL NEOPLASMS

Panel:
CHARLES G. CHILD III
Atlanta, GA
MARION C. ANDERSON
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Georgia Urological Association

Program Chairman
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WILLIAM H. BOYCE, Professor and Chairman, Department of Urology, Bowman Gray School of Medicine, Winston-Salem, NC
HARRY GRABSTALD, Associate Professor of Urology, Cornell University Medical College, New York, NY

Friday, November 16, 9:00 a.m.

Presiding:
Woodrow W. Payne
President
Georgia Urological Association
Brunswick, GA

9:00-9:05

OPENING REMARKS

WOODROW W. PAYNE
Brunswick,GA

9:05-10:00

SURGERY OF RENAL CELL CARCINOMA

HARRY GRABSTALD
Guest Speaker
New York, NY

10:00-10:30

OPEN DISCUSSION — PRESENTATION OF CASES

INTERMISSION

10:45-11:45

EVALUATION AND NON-SURGICAL MANAGEMENT OF RECURRENT RENAL CALCULI

WILLIAM H. BOYCE
Guest Speaker
Winston-Salem, NC

11:45-12:15

OPEN DISCUSSION — PRESENTATION OF CASES

Saturday, November 17, 9:00 a.m.

Presiding:
Ronald Roper
Secretary
Georgia Urological Association
Marietta, GA

9:00-10:00

CURRENT MANAGEMENT OF TESTIS TUMORS

HARRY GRABSTALD
Guest Speaker
New York, NY

10:00-10:30

OPEN DISCUSSION — PRESENTATION OF CASES

INTERMISSION

10:45-11:45

SURGICAL MANAGEMENT OF RENAL CALCULI

WILLIAM H. BOYCE
Guest Speaker
Winston-Salem, NC

11:45-12:15

OPEN DISCUSSION — PRESENTATION OF CASES

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Frank Finnerty, M.D., Washington, D.C.

"Hypertension in the Elderly"
John Raisley Coope, M.D., MRCGP, Macclesfield, England

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Edward Frohlich, M.D., New Orleans, Louisiana

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Robert G. Wilcox, M.D., MRCP, Nottinghamshire, England

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The overall objectives of this symposium are to provide practical information useful in the office management of hypertension, and to evaluate successful and current treatment programs in the United States and the United Kingdom.

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Management of Allergic Reactions to Stinging Insects

ALLERGIC REACTIONS to stinging insects, primarily the hymenoptera (bee, wasp, hornet, and yellow jacket), continue to account for significant morbidity and occasional deaths. In Georgia and other southern states, the imported fire ant has spread northward and is causing an increasing number of generalized reactions. Physicians have a responsibility to provide not only appropriate treatment for the acute reaction but to educate the patient regarding the risk of future stings. No long-term follow-up studies have been done on untreated patients, but it is clear that patients treated by desensitization with whole-body extract, as they have been in the past, may continue to be at risk of severe reactions if they are re-stung. Venom extracts which offer better protection may soon be available, yet they cannot be expected to offer absolute protection.

Patients and/or other members of their families who have had generalized reactions require extensive instruction regarding the avoidance and treatment of future stings. Brochures for patient education and information are available.* These contain tips on avoidance of stings and give general suggestions regarding treatment of future stings.

Basically, epinephrine is the drug of choice for acute allergic reactions of any significance, because it helps counteract all the physiologic abnormalities. The beta adrenergic effect causes bronchodilitation and probably decreases further release of the mediators, while the adrenergic effects combat vasodilitation and shock as well as edema of the airway. In the appropriate dosage (0.01 ml/kg, maximum .5 ml), severe side effects are unusual, but care is needed when the patient has pre-existing heart disease or hypertension. Since for those at acute risk the average time that elapses between the sting and death is usually only a few minutes, it is essential that patients at risk have adrenalin available in case they cannot reach medical help. Kits are available which contain aqueous adrenalin 1 : 1000 in a preloaded syringe which delivers up to .3 ml doses.† Chewable antihistamine tablets are included as well as a loop-type tourniquet which the patient can apply if stung on an extremity. One may add a small bottle of syrup of ephedrine which may provide more long lasting alpha and beta adrenergic effects. Patients at risk, those who have a history of generalized reaction, should have kits accessible at home, school, work, or vacation, and they should be instructed in their use. If they are stung, they should apply a tourniquet and/or ice if possible, take the antihistamine and ephedrine orally, and get to a medical facility. If alarming symptoms occur, they should inject the specified dose

* Allergy Foundation of America, 801 2nd Avenue, New York, NY 10017.

† Hollister Stier Laboratories, P.O. Box 19957, Atlanta, GA 30325.

of adrenalin subcutaneously with a repeat dose possible if absolutely necessary. Patients and/or parents should have an opportunity to practice with a syringe in the office mainly to lessen their fear of using a needle.

School nurses or principals, camp counselors, lifeguards, and other such persons should be trained to recognize an anaphylactic reaction and to provide emergency treatment. The public should be taught that other sources of adrenalin such as cartridge nebulizers (Medihaler-Epi, Primatene mist) may be helpful, especially with upper airway edema, if injectable adrenalin is not available in such a situation. The need for public education is dramatized by a recent obituary of a physician stung fatally in his own front yard. His neighbors didn't know how to help.

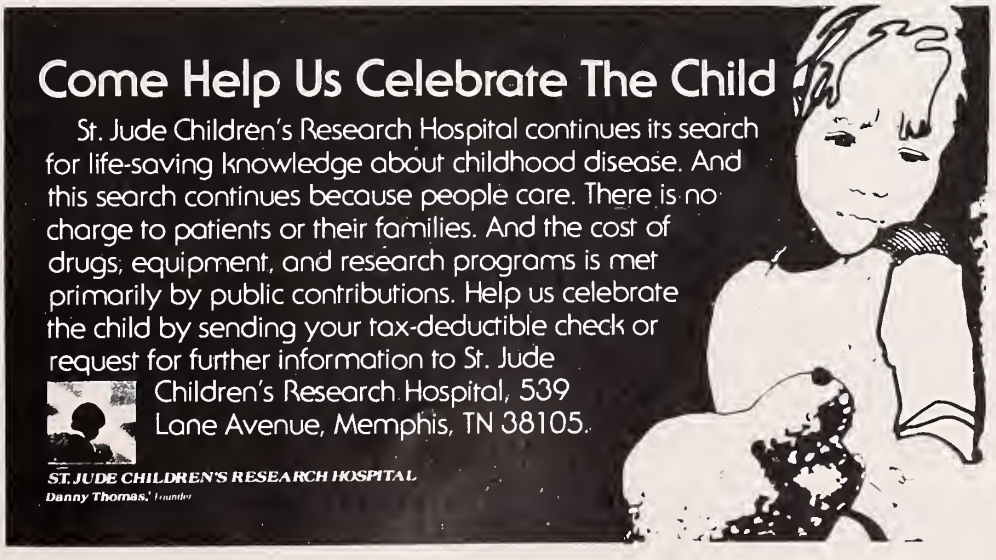
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It is with regret and a feeling of nostalgia that we announce the discontinuance of one of our most popular features. Because of other commitments, Dr. J. G. McDaniel has decided that he can no longer continue his widely read page, "I've Told This Before."

Many of our readers from time to time have suggested that these unusual and entertaining anecdotes be assembled and published into a single volume. This would indeed be a collector's item. For those of you who share our enthusiasm for these rare yarns, an expression of your desire to see these published might just induce "Dr. Mac" to consider such a venture. Thank you, Dr. McDaniel, for your contributions to the *Journal*. We are all indebted to you.

Edgar Woody Jr., M.D.



cancer page
cancer page
cancer page

A Screening Technique for Endometrial Cancer

FRANK F. MIDDLETON III, M.D., *Albany**

Introduction

CONSIDERABLE ATTENTION has been directed toward developing an accurate, inexpensive, and well-tolerated screening technique for endometrial cancer. The remarkable degree to which the Pap smear achieves this goal in the diagnosis of cervical cancer sets the standard. Such a technique for endometrial cancer detection might then be extended to the asymptomatic patient at high risk and eventually to all women.

There are many reports in the literature describing outpatient, endometrial sampling techniques. These include attempts to recover endometrial cells for cytologic preparations and tissue appropriate for histologic study.

The endometrial biopsy must be considered the standard outpatient technique. Extensive favorable experience has been reported by Hoffmeister,[1] Maudsley and Johnson,[2] and Hathcock et al.[3] In their review of histologic screening for endometrial cancer, Cohen, Gusberg, and Koffler[4] observed that few reports detailed subsequent hospital curettage so that comparison with the traditional method of evaluation could be made. Kahler et al.[5] did follow endometrial biopsy with dilatation and curettage (D & C) or hysterectomy in 160 patients. When an endometrial biopsy was obtained, the diagnosis at subsequent D & C or hysterectomy was the same in 96% of the cases.

Various instruments, such as rotating brushes and an endometrial sponge, have been devised to facilitate recovery of suitable endometrial samples for histologic study. The Novak or Randall curette has been even more popular. Perhaps the most popular instrument used to recover endometrial cytologic samples is the Gravelee jet washer, introduced in 1964. Many reports attest to the accuracy of this technique in revealing endometrial malignancy.[6, 7, 8] Not all investigators were able to accomplish satisfactory accuracy, however. Twiggs et al.[9] reported a large outpatient series using the jet washer and noted the technique failed to demonstrate 14 of 25 endometrial cancers. In 10 of those 14, the specimen was considered unsatisfactory. With any cytologic technique, there is the frequent complaint that premalignant atypia are unreliably detected, and some pathologists may lack the experience to evaluate endometrial cellular abnormalities.

Description of Study

With these observations in mind, it seemed appropriate to examine the results of the technique used to screen for endometrial cancer in our office. The charts of 293 patients who had undergone a total of 346 procedures from September 1975 to February 1979 were reviewed.

* Dr. Middleton is an obstetrician-gynecologist. His address is 907 N. Jefferson St., Albany, GA 31701. Prepared at the request of the Georgia Division, American Cancer Society. Others wishing to contribute papers to this page are invited to send them to David B. Roberts, M.D., 2400 13th St., Columbus, GA 31906.

TABLE 1 — Age Distribution of Patients Screened for Endometrial Cancer, September 1975 — February 1979, Albany, GA

Age (Years)	Number	Percent
< 30	6	(2)
30-39	51	(17)
40-49	145	(50)
50-59	84	(29)
⩾ 60	7	(2)
Total	293	(100)

The ages of the patients ranged from 23 to 78 (Table 1). Indications for the procedure were similar to those for D & C. Abnormal uterine bleeding was present in 88%. An additional 10% had previously identified endometrial pathology, and repeat sampling was indicated.

Patients were not considered candidates for this procedure when obesity, colpostenosis, cervical stenosis, or other physical conditions made exposure of the cervix and instrumentation of the uterine cavity difficult. Similarly, if a patient elected hospital curettage with anesthesia or her anxiety did not permit satisfactory cooperation, outpatient management was not attempted.

The endometrial sample was obtained with the Vabra* suction endometrial biopsy instrument. The curette is a metal cannula with an outside diameter of 3 mm. and a perforation on its concave distal tip 1.5 x 16 mm. The cannula is connected by polyethelene tubing to a suction pump that develops a negative pressure of 50 to 60 cm. Hg. when the pressure equalizing holes near the base of the cannula are occluded. A plastic collection chamber fits between the tubing and the curette to trap the specimen.

Technique

The procedure was explained to all patients, and they were given the opportunity to elect hospitalization. No anesthesia was used. After bimanual examination, the cervix was visualized and cleaned with an antiseptic solution. The anterior lip of the cervix was stabilized with a tenaculum and the uterus sounded to confirm position. Occasionally, the cervix was too stenotic to admit the sound but did allow passage of the smaller diameter curette, and in these patients curettage was accomplished without prior sounding.

After introduction of the curette, the suction pump was applied and the pressure equalizing holes covered. The entire cavity was curetted with special attention to the cornual regions. Only 12 specimens were considered inadequate for pathologic diagnosis. Pathologic findings in the remaining 334 are summarized in Table 2.

* Cooper Laboratories, Inc., Bedford Hills, New York.

TABLE 2 — Histologic Diagnosis, Endometrial Cancer Screening, September 1975-February 1979, Albany, GA

Diagnosis	Number	Percent
Normal endometrium	167	(48)
Hyperplasia, benign	98	(28)
Adenomatous hyperplasia	44	(13)
Carcinoma	6	(2)
Endometrial polyps and miscellaneous	19	(6)
Inadequate tissue	12	(3)
Total	346	(100)

Sixty-five patients subsequently had either a standard D & C or hysterectomy within 6 months of the office procedure. The histologic diagnosis agreed or was no more severe in the final specimen of 58 patients. Table 3 outlines the seven patients in which a discrepancy in their specimens existed. Four patients had endometrial carcinoma not demonstrated by the suction biopsy. Three of the four had the tumor confined to a polyp, and in the other one the process was focal. Two patients had adenomatous hyperplasia, while the office biopsy had shown only proliferative hyperplasia. The final patient with discrepancy had proliferative endometrium on suction curettage and proliferative hyperplasia on hospital D & C.

TABLE 3 — Seven Patients Screened for Endometrial Cancer With Discrepancies in Histologic Diagnosis, September 1975-February 1979, Albany, GA

Patient	Age (years)	Suction Curettage	"Standard" D & C or Hysterectomy
J. S.	46	Endometrial polyps	Adenocarcinoma, focal
R. J.	50	Adenomatous hyperplasia	Adenoacanthoma in a polyp
M. B.	51	Proliferative endometrium	Endometrial hyperplasia
D. C.	55	Adenomatous hyperplasia	Adenoacanthoma in a polyp
N. J.	49	Endometrial hyperplasia	Adenomatous hyperplasia
L. C.	70	Atrophic endometrium	Adenocarcinoma in a polyp
R. J.	52	Endometrial hyperplasia	Adenomatous hyperplasia

Complications

Two patients developed significant inflammatory disease within 48 hours of the procedure and required hospitalization. One of these developed an inflammatory mass that resolved on antibiotic therapy. There were no known or suspected perforations.

Discussion

Vabra suction biopsy has been reported by several authors.[10-13] These reports attempt to evaluate the procedure with regard to patient acceptance and reliability of the histologic diagnosis. There is a lack of agreement on the degree of patient discomfort associated with this procedure. Walter[14] reported 79% felt slight to moderate pain, and 21% noted severe pain, but in a series reported by Bjerre,[15] 82% experienced "no real discomfort." The discomfort of the procedure is frequently compared to dysmenorrhea and IUD insertion.

Complications, such as the apparent pelvic infection in this series of patients, have not been reported; however, one uterine perforation occurred in a group of 50 patients reported by Nye.[16]

The reliability of the histologic diagnosis has been substantiated by correlation with subsequent D & C and/or hysterectomy in several series. Cohen and Gusberg[17] discovered nine out of nine cancers, and in 95% of patients, the diagnosis obtained at D & C or hysterectomy correlated with the suction biopsy. Lutz detected 25 of 29 malignancies, but this series was highly selected, and many had had a previous curettage within 1 week of the procedure. It must be kept in mind that histologic correlation may be improved when the Vabra suction is done under anesthesia just prior to D & C or hysterectomy.

An interesting observation made by Saunders and Rowland[18] suggested that the Vabra suction biopsy specimen showed vacuolation of the glandular epithelial cells and stromal edema that were essentially artifacts. This would certainly be important in those patients for whom the procedure was done as a part of infertility evaluation. The pattern might be mistakenly interpreted as secretory endometrium in the absence of ovulation. This effect has not been noted in other reports nor was it specifically looked for in our material. The fact that adnexal or parametrial infection developed in two of our patients may make this technique undesirable for infertility evaluation.

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PERSONALS

First District

Mel Berlin, M.D., of Savannah, has accepted a position as coordinator of sports medicine at Duke University and member of the faculty at the school's Medical College.

James C. Metts Jr., M.D., Savannah, has organized a medical mission to the Republic of Haiti (July 24-30) for which more than 40 volunteers have signed up. Other MAG members who have volunteered for the trip are **Wesley Ball, M.D.,** surgeon, and **Marvin Bedingfield, M.D.,** orthopedist, both of Savannah.

Ivy Shuman Jr., M.D., Sylvania, has been named a Diplomate of the American Board of Family Practice.

Second District

The June 15 issue of the *Thomasville Times-Enterprise* honored **John Thomas King Sr., M.D.,** for his 54 years of service to Thomasville residents.

Robert T. Morgan, M.D., of Sylvester, has recently joined the staff at Americus and Sumter County Hospital as an emergency room physician.

Joe Turner, M.D., of Tifton, president of the Georgia Heart Association (GHA), spoke May 29 at a GHA fund-raising banquet at the Elks Lodge in Fitzgerald.

Fifth District

Joseph Baird, M.D., Chief of the medical staff at Peachtree and Parkwood Mental Health Center and Hospitals in Atlanta, has been elected President of the Georgia Psychiatric Association.

John Bostwick III, M.D., Assistant Professor of Surgery at Emory University in Atlanta recently received the James Barrett Brown Award from the American Association of Plastic Surgeons for his contributions to research and knowledge in plastic surgery.

John K. Daviddson III, M.D., Ph.D., of Atlanta, has earned the 1979 Upjohn Award as the Outstanding Educator in the Field of Diabetes.

Jess C. Lester, M.D., a Snellville ophthalmologist, was awarded the honorary Doctor of Science degree from Asbury College, Wilmore, Kentucky, during commencement exercises on June 4.

A former chairman of the Emory Department of Surgery, **John D. Martin Jr., M.D.,** has written a new book entitled, "The History of Surgery at Emory University School of Medicine."

In their June 17 issue, the *Atlanta Daily World* honored **Homer Nash, M.D.,** as being one of the oldest practicing physicians in Atlanta. Dr. Nash is 92.

Sixth District

T. A. Sappington, M.D., of Thomaston, has been honored by the Georgia Academy of Family Physicians with the establishment of a scholarship in his name for deserving high school students.

Seventh District

Joseph G. Bussey Jr., M.D., F.A.C.S., of Austell, presented a paper entitled, "Transcutaneous Nerve Stimulation for Postoperative Pain Control" on June 16, 1979, at the University of Graz in southern Austria. Dr. Bussey was the guest of the Austrian Medical Society.

Jack Gent, M.D., and his wife were the honorees at a dinner held at the Top O' Ellijay on May 21. Dr. Gent has recently joined the staff of Watkins Memorial Hospital in Gilmer County.

Mark A. Gould, M.D., has been elected the first chairman of the newly formed Professional and Technical Advisory Committee to the Accreditation Program for Psychiatric Facilities of the Joint Commission on Accreditation of Hospitals. The initial meeting was held June 2 in Chicago.

The *Rome News-Tribune* honored **Tom Moss Sr., M.D.,** recognizing his 50 years of medical service.

Luis M. Viamonte, M.D., of Dalton, was elected to Fellowship in the American Academy of Pediatrics at a recent meeting of its executive board in Toronto, Canada.

Eighth District

J. Donald James, M.D., of Waycross, has been honored by accreditation from the American Board of Obstetrics and Gynecology.

Roger K. Russell, M.D., Florida, has recently been given a special plaque by the Atkinson County Training Center in recognition of his medical services to the Center. For the past 3 years, Dr. Russell has given all Special Olympics participants the physical check-ups needed for taking part in Special Olympics games.

Roy Thagard, M.D., medical director and staff physician for the Glynn County Mental Health Center, was one of three speakers on a substance abuse panel at the American Association of University Women's "Back to Basics" in Brunswick.

Ninth District

C. D. Gilbert, M.D., and **James C. Pickens, M.D.,** both of Toccoa, have been recertified recently by the American Board of Obstetrics and Gynecology.

Tenth District

Augusta physician, **William S. Boyd, M.D.,** received the honorary Doctor of Science degree from Newberry College in Newberry, S.C., during commencement exercises May 27.

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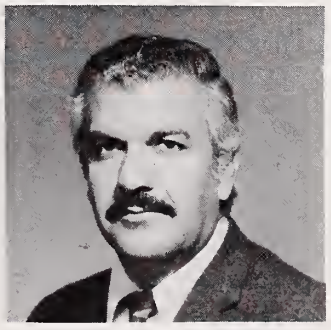
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SOCIETIES

The **Flint Medical Society** has its own historian. Charles McArthur, M.D., of Cordele, has researched the society's 75-year history, gleaning facts from the minutes of past meetings.

The **Whitfield-Murray County Medical Society** met June 19 at the Dalton Elks Club. Among other items of business, Kenneth L. Jones Jr., M.D., presented a paper on surgical infections.

DEATHS

Lewis R. Lang

Louis R. Lang, M.D., 64, of Calhoun, died on Tuesday, May 29. Dr. Lang was a graduate of the University of Georgia and the George Washington Medical School. He is survived by a sister, and several nieces and nephews.

T. C. Moseley

T. C. Moseley, M.D., 53, died Friday, March 16. He had practiced obstetrics and gynecology in Atlanta since 1956.

A native of Pellville, Kentucky, Dr. Moseley received his B.S. degree in 1949 and his M.D. degree in 1952, both from Indiana University. He was a member of the Phi Rho Sigma medical fraternity.

Dr. Moseley served his residency at Georgia Baptist Hospital. He was a staff member of Decatur Hospital and DeKalb General Hospital. He was a member of the Medical Association of Georgia and the DeKalb County Medical Society, serving as chairman of the sex education committee for several years. He was a member of the American Cancer Society and received the Outstanding Physician Award in 1972 from the Nurses Association of Georgia.

Dr. Moseley worked actively in the Boy and Girl Scouts of America organizations. He was a member of the Parent-Teacher Association of Lakeside High School and was co-president of the DeKalb County Council of PTA.

He was a Diplomate of the American College of Obstetrics and Gynecology, a member of the American Fertility Society, and a member of the Atlanta Obstetrics and Gynecology Society.

Survivors include his wife, a daughter, a son, and his mother.

Claude-Starr Wright

Claude-Starr Wright, M.D., 62, a professor of the Medical College of Georgia, died Tuesday, June 12, at his residence.

Dr. Wright was a native of Laurens, S.C., and had lived in Augusta 25 years. He was a member of the Saint Mary's Catholic Church, and served as Professor of Medicine; Director of Education and Curriculum, Department of Medicine; and formerly chief, Section of Hematology at the Medical College of Georgia.

Survivors include his wife, three sons, and two daughters.

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Brief Summary
INDICATION: Tenuate and Tenuate Dospan are indicated in the management of exogenous obesity as a short-term adjunct (a few weeks) in a regimen of weight reduction based on caloric restriction. The limited usefulness of agents of this class should be measured against possible risk factors inherent in their use such as those described below.
CONTRAINDICATIONS: Advanced arteriosclerosis, hyperthyroidism, known hypersensitivity, or idiosyncrasy to the sympathomimetic amines, glaucoma. Agitated states. Patients with a history of drug abuse. During or within 14 days following the administration of monoamine oxidase inhibitors, (hypertensive crises may result).
WARNINGS: If tolerance develops, the recommended dose should not be exceeded in an attempt to increase the effect; rather, the drug should be discontinued. Tenuate may impair the ability of the patient to engage in potentially hazardous activities such as operating machinery or driving a motor vehicle; the patient should therefore be cautioned accordingly. *Drug Dependence:* Tenuate has some chemical and pharmacologic similarities to the amphetamines and other related stimulant drugs that have been extensively abused. There have been reports of subjects becoming psychologically dependent on diethylpropion. The possibility of abuse should be kept in mind when evaluating the desirability of including a drug as part of a weight reduction program. Abuse of amphetamines and related drugs may be associated with varying degrees of psychologic dependence and social dysfunction which, in the case of certain drugs, may be severe. There are reports of patients who have increased the dosage to many times that recommended. Abrupt cessation following prolonged high dosage administration results in extreme fatigue and mental depression; changes are also noted on the sleep EEG. Manifestations of chronic intoxication with anorectic drugs include severe dermatoses, marked insomnia, irritability, hyperactivity, and personality changes. The most severe manifestation of chronic intoxications is psychosis, often clinically indistinguishable from schizophrenia. *Use in Pregnancy:* Although rat and human reproductive studies have not indicated adverse effects, the use of Tenuate by women who are pregnant or may become pregnant requires that the potential benefits be weighed against the potential risks. *Use in Children:* Tenuate is not recommended for use in children under 12 years of age.
PRECAUTIONS: Caution is to be exercised in prescribing Tenuate for patients with hypertension or with symptomatic cardiovascular disease, including arrhythmias. Tenuate should not be administered to patients with severe hypertension. Insulin requirements in diabetes mellitus may be altered in association with the use of Tenuate and the concomitant dietary regimen. Tenuate may decrease the hypotensive effect of guanethidine. The least amount feasible should be prescribed or dispensed at one time in order to minimize the possibility of overdosage. Reports suggest that Tenuate may increase convulsions in some epileptics. Therefore, epileptics receiving Tenuate should be carefully monitored. Titration of dose or discontinuance of Tenuate may be necessary.
ADVERSE REACTIONS: *Cardiovascular:* Palpitation, tachycardia, elevation of blood pressure, precordial pain, arrhythmia. One published report described T-wave changes in the ECG of a healthy young male after ingestion of diethylpropion hydrochloride. *Central Nervous System:* Overstimulation, nervousness, restlessness, dizziness, jitteriness, insomnia, anxiety, euphoria, depression, dysphoria, tremor, dyskinesia, mydriasis, drowsiness, malaise, headache; rarely psychotic episodes at recommended doses. In a few epileptics an increase in convulsive episodes has been reported. *Gastrointestinal:* Dryness of the mouth, unpleasant taste, nausea, vomiting, abdominal discomfort, diarrhea, constipation, other gastrointestinal disturbances. *Allergic:* Urticaria, rash, ecchymosis, erythema. *Endocrine:* Impotence, changes in libido, gynecomastia, menstrual upset. *Hematopoietic System:* Bone marrow depression, agranulocytosis, leukopenia. *Miscellaneous:* A variety of miscellaneous adverse reactions has been reported by physicians. These include complaints such as dyspnea, hair loss, muscle pain, dysuria, increased sweating, and polyuria.
DOSAGE AND ADMINISTRATION: Tenuate (diethylpropion hydrochloride): One 25 mg. tablet three times daily, one hour before meals, and in midevening if desired to overcome night hunger. Tenuate Dospan (diethylpropion hydrochloride) controlled-release: One 75 mg. tablet daily, swallowed whole, in midmorning. Tenuate is not recommended for use in children under 12 years of age.
OVERDOSAGE: Manifestations of acute overdosage include restlessness, tremor, hyperreflexia, rapid respiration, confusion, assaultiveness, hallucinations, panic states. Fatigue and depression usually follow the central stimulation. Cardiovascular effects include arrhythmias, hypertension or hypotension and circulatory collapse. Gastrointestinal symptoms include nausea, vomiting, diarrhea, and abdominal cramps. Overdose of pharmacologically similar compounds has resulted in fatal poisoning, usually terminating in convulsions and coma. Management of acute Tenuate intoxication is largely symptomatic and includes lavage and sedation with a barbiturate. Experience with hemodialysis or peritoneal dialysis is inadequate to permit recommendation in this regard. Intravenous phentolamine (Regitine®) has been suggested on pharmacologic grounds for possible acute, severe hypertension, if this complicates Tenuate overdosage.

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References: 1. Citations available on request—Medical Research Department, MERRELL RESEARCH CENTER, MERRELL-NATIONAL LABORATORIES, Cincinnati, Ohio 45215. 2. Hoekenga, M.T., O'Dillon, R.H., and Leyland, H.M.: A Comprehensive Review of Diethylpropion Hydrochloride. International Symposium on Central Mechanisms of Anorectic Drugs, Florence, Italy, Jan. 20-21, 1977.

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J-6999-4

April 1979

Obtaining Adequate Compensation for Your Expert Testimony

JAMES C. RAWLS, *Atlanta**

WHAT STEPS can a physician lawfully take to make certain that he or she obtains adequate compensation for time spent preparing for and giving testimony in court? Absent any legislative change in Georgia, it appears that physicians can be compelled to testify, but nothing further, for the minimum statutory compensation. Even so, there are some suggestions available to minimize uncompensated time.

Legal Precedents

A survey of the very small amount of Georgia law on the subject is in order first. In *Dixon v. State,*[1] the Georgia Court of Appeals held:

> "Only when expressly provided by law can the privilege of a witness resist the demand of justice for the truth, and the witness refuse to answer a legal question. A physician is competent to testify as an expert, and no expert can refuse to testify because he has not been compensated or will not be compensated for his testimony. An expert testifying as a witness has no greater privilege than any other witness."

Earlier, in the case of *Schofield v. Little,*[2] the same Court had stated:

> "While no statute in Georgia allows or prohibits fees to expert witnesses, and while there can be no charge beyond the legal fees of ordinary witnesses for attendance on the Court in obedience to subpoenas, still, as a physician cannot be required to make any examination or preliminary preparations, or to listen to the testimony, in order the better to give his opinion as an expert, he may for such (additional) services demand extra compensation."

These decisions have never been departed from in Georgia, and state what appears to be the majority rule in this country: that the search for truth demands that every witness, whether an expert or not, give relevant testimony when required to do so by lawful process, regardless of the fact that the testimony may be the product of considerable training, education, and experience. For such testimony, even though it may constitute in whole or in part a rendering of expert opinions, the witness is entitled only to the statutory witness fee of $4.00 per day, together with mileage fees if the witness resides outside the county where the testimony is required.[3] (In federal court the principles are the same, although the witness fee and mileage fees are somewhat higher.) As stated in *Schofield,* however, the requirement that experts give testimony without special compensation does not mean that the expert must also render collateral services such as preparation, examination, study, independent research, evaluation of other testimony or other expert opinions, etc. It is clear that the expert may quite properly decline to render any such services without compensation for the reasonable value of his time.

* Prepared at the request of the Medical Association of Georgia. Mr. Rawls is an associate in the firm of Powell, Goldstein, Frazer, and Murphy, General Counsel to the Association, 1100 C & S National Bank Building, Atlanta, GA 30303.

The existing Georgia cases all deal with testimony at trial, and there is no Georgia case dealing with whether the same principles are applicable to testimony given at a deposition. Since physicians' depositions are often taken for use in evidence, and may be taken pursuant to subpoena just as the expert may be required to testify at trial pursuant to subpoena, it is quite probable that at least for depositions which are taken for use in evidence, the same principles will be held to apply.[4]

Community Guidelines

In addition to the binding principles of law described above, there exist in various communities recommended guidelines established cooperatively by the medical and legal professions, such as the "Principles Governing Physician-Lawyer Relationships" promulgated by the Atlanta Bar Association and the Medical Association of Atlanta (the "Principles"). These represent salutary efforts to engender harmonious relations between the professions, and if adhered to by both physicians and attorneys, will avoid most problems concerning physicians' compensation. For example, the Principles provide that "a reasonable expert witness fee is a proper and necessary item of expense in litigation involving medical questions," and that such a fee should be based upon time actually spent (including time in court as well as time in preparation). The Principles go on to suggest that fees be discussed by the physician and attorney in advance of the services and testimony, and provide that while the primary obligation of payment is of course on the client-patient (attorneys being ethically barred in most cases from paying such charges), it is deemed the obligation of the attorney to make adequate arrangements for payment of the witness fees of the physician, and to use every legitimate means to see that the charges of the physician are paid by the client. Nonbinding mediation or arbitration by the Joint Medical-Legal Committee is available for referrals of disagreements.

Minimizing Uncompensated Time

In most cases physicians who are called upon to give testimony as expert witnesses should, as a practical matter, have little difficulty making adequate arrangements for compensation. An attorney desiring a physician's testimony will usually contact the physician well in advance of the occasion on which the testimony is needed, and the physician should seek to reach an understanding on that occasion concerning the amount of the fee and arrangements for payment. Ordinarily the attorney will agree to payment of a reasonable fee for the physician's time even though the required testimony could, in accordance with Georgia law, be procured by subpoena accompanied by the per diem fee and mileage fees. This is true not only because the sensible attorney will respect the value of the physician's time but because he does not desire to engender hostility which might affect the physician's testimony; furthermore, the attorney will understand that reasonable compensation provides an incentive to the physician to make adequate preparation for the testimony, while the payment of the minimal statutory fees, on the other hand, discourages the physician from spending much time reviewing his records or preparing in any way.

Physicians may well help themselves in the long run by declining to do anything more than to appear and testify in response to a subpoena in those cases involving attorneys who refuse to provide for reasonable compensation. This approach would be most effective in cases in which the physician actually treated or examined the patient, since in such cases the physician would, by declining to review his records in preparation for testimony, succeed in frustrating the attorney requiring the testimony. Even where the physician is disassociated from the case and has not observed any patient or matter in issue, the physician may be compelled to render expert testimony in the abstract if relevant to the case upon payment of only the statutory fees. Here, however, the practical circumstances make it less likely that attorneys will take advantage of the legal right to obtain the physician's testimony at bargain prices. For the attorney will very probably not even know the content of a physician's testimony until the physician accepts engagement as an expert witness upon terms satisfactory to the physician, and attorneys have a just and well-

developed fear of placing a witness on the stand without a confident expectation of the content of the witness' testimony. Unless the physician has committed himself to certain views in print, the physician can, and perhaps should, firmly refuse to volunteer his opinions in response to informal inquiries by attorneys until satisfactory terms and conditions of the physician's engagement are agreed to.

Despite the best efforts of a physician to arrange for a fair payment for his time spent in testifying, however, there will invariably be attorneys who will take advantage, quite lawfully, of the right to require a physician to testify for minimal compensation. Occasionally, for example, where the client is indigent or where the physician's compensation requirements are deemed to be unreasonable, and the physician's testimony is deemed essential, this practice may be the only effective method of meeting the client's needs, and therefore the attorney may be ethically required to resort to this practice. In addition, it may be expected that from time to time attorneys will, either out of discourtesy or inadvertence, require that the demand upon the physician's time be far greater than that necessary for the physician's testimony to take place, and the physician may find himself legally required to spend wasted hours or even days waiting at a courthouse to testify. In such instances a comment by the physician to the judge would be appropriate and might well result in the judge's excusing the witness or rebuking the attorney.

However, there is very little that the physician can do in such cases to insure that he is compensated for his time actually spent in testifying or waiting to testify in response to a subpoena. One suggestion is that physicians include in their contracts with patients a provision for payment of an additional fee should the patient call upon the physician for testimony concerning the physician's treatment or the patient's condition. (This of course would not help in those rare situations in which the physician is called to testify despite his complete disassociation from a given case, but the likelihood of abuse is much less in these types of cases, as discussed above.) While in most cases such a provision would likely be adhered to, it is quite possible that, if challenged, such a provision might be held to be contrary to public policy based on the *Dixon* case described above. It is also conceivable that the courts would hold that such a provision in a contract is without consideration, since testifying in appropriate cases is the legal duty of a physician and of everyone else for which extra compensation may not be required. Certain decisions in jurisdictions other than Georgia appear to foreshadow these results.[5]

The only complete solution to the problem faced by physicians and other experts is legislative action. Certain states have enacted statutes which afford some relief by providing that experts who render opinion testimony (not facts known by the expert) are entitled to certain fees in addition to ordinary witness fees (often set by the court in its discretion).[6]

It is difficult to judge the likelihood of adoption by the Georgia General Assembly of such a provision designed to protect the expert medical opinions of physicians. So far as a physician's factual knowledge is concerned, however, it is highly unlikely that any legislature would be persuaded to allow a physician or other experts to withhold testimony of facts such as those concerning a person's medical condition and treatment of which the physician or other expert has personal knowledge; and even if passed, such a statute would appear to be subject to attack on constitutional grounds.

Notes

1. 12 Ga. App. 17 (1912). 2. 2 Ga. App. 286 (1907). 3. Ga. Code Ann. §38-801

4. Where a physician or other expert has been engaged by one party to litigation to serve as that party's expert, provision is made by the Georgia Civil Practice Act and by the Federal Rules of Civil Procedure for the expert to be compensated by a "reasonable fee" (reasonableness to be determined by the Court if disputed) for the time spent by the expert participating in discovery (depositions or requests for documents) requested by *other* parties. (*Ga. Code Ann.* §81A-126(b)(4)(A); Federal Rules of Civil Procedure, Rule 26(b)(4)(C).)

5. *Hartley v. Alabama National Bank of Montgomery,* 247 Ala. 651, 25 So.2d 680(1946); *Swope v. State,* 145 Kan. 928, 67 P.2d 416 (1937); *Barnes v. Boatmen's National Bank of St. Louis,* 348 Mo. 1032, 156 S.W.2d 597 (1941)

6. See, for example, N.M.S.A. §20-1-4, (Repl. Vol. 4, 1970) (New Mexico), F.S.A. 90.231(2) (Florida), M.S.A. §27A-2164(1)(Michigan), and L.S.A. — R.S. 13:3666(Louisiana)

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MAG — Current Programs and Future Goals

EARNEST C. ATKINS, M.D., *Atlanta**

On June 23 and 24, 1979, the Executive Committee and staff of the Medical Association of Georgia (MAG) met at the Perimeter Marriott Hotel in Atlanta to discuss and define what the purposes, goals, and priorities of the MAG should be. We met from 9:00 a.m. to 7:00 p.m. on Saturday and from 8:00 a.m. to noon on Sunday. I heartily commend all those who participated in this important meeting.

The discussions were candid and unrestrained. The following is my interpretation of what transpired.

I. A lengthy presentation by executive staff members of individual functions was first. This will be mailed to all board members and is available to all members. Our staff deserves our appreciation and respect for the multiplicity and complexity of the tasks they perform so capably.

II. We could not change, or even suggest, improvements on the purposes of the Association as stated in the Constitution and Bylaws as revised by the House of Delegates at the Annual Session on April 24, 1977.

CONSTITUTION

ARTICLE II — PURPOSES OF THE ASSOCIATION

The purposes of the Association are to promote the science and art of medicine and the betterment of public health as provided for in the Bylaws.

BYLAWS

CHAPTER 1 — PURPOSES OF THE ASSOCIATION

SECTION 1. The purposes of the Association as specified in the Constitution shall be met in the following ways:

(a) Establish the federation of organized medicine through the chartering of constituent county medical societies in Georgia and, by joining with similar state medical associations, constitute the American Medical Association.

(b) Promote the provision of quality medical care at reasonable cost with fair remuneration to the physician.

(c) Encourage the maintenance of the physician-patient relationship as an essential in the delivery of quality medical care.

(d) Seek to assure all Georgians access to quality medical services regardless of their financial condition, geographic location or sophistication in using the health care systems.

(e) Advance the scientific, socio-economic and medical-political knowledge of the profession so that the members may better serve their patients, their community and their association.

(f) Maintain the highest standards of professional conduct and adhere to the Principles of Medical Ethics set forth by the AMA.

(g) Support reasonable expansion of the number of persons entering the medical and allied health professions, as well as assure that the best qualified individuals are admitted into the professions in order to meet the established needs for such manpower in Georgia.

(h) Reinforce recognition of an ongoing, life-long need for continuing medical education in the art and science of medicine through participation in programs of continuing education.

(i) Establish and provide specific services to the membership which meet its needs.

III. Our goals were viewed and discussed from many different angles. Here is my vantage point.

A. Membership Services — This is clearly stated in the Bylaws (Section 1).

1. Recruitment of new members

a. MAG — We have over 4,700 of the 6,300 physicians in Georgia eligible for membership. This year I would like to see us increase our count by 10% (470), but this year let us go for

* Dr. Atkins is President of the MAG.

quality as well. Let us make MAG so vital to medicine in our state that it will truly enhance your professional status to be a member.

b. AMA — My goal for AMA membership is to have enough MAG members this year for us to qualify for a fifth AMA delegate. If half the MAG non-AMA members joined, this would be accomplished. Urge those you know who are not members to join us in our efforts to effect a positive impact on organized medicine.

c. Residents — These are the young doctors of tomorrow who will succeed us in organized medicine. To interest them, we should offer them a voice and a vote. We can capitalize on the experience of AMA's residents and interns business section or even have a component society for them comparable to our component county societies.

d. Interns — These doctors will take our place day after tomorrow. It is impossible to over-emphasize the value of these young minds with new ideas. We should encourage them to join our ranks early.

e. Students — To interest students in organized medicine we must first get the support of their teachers. What about a Chair of Private Practice in each of our three medical schools? I recommend them, and MAG can easily support them.

2. Information

a. Newsletter — This gives current news monthly and, with thanks for the support by Roche Laboratories, we plan to continue.

b. The *Journal of the MAG* — Read this issue from cover to cover and you will join me in thanking our editor, managing editor, and contributors for this prize-winning publication.

c. Telephone calls — A vital area of rapid communication where we can be of service to our members, no matter how time-consuming to our staff and officers. Call us: 404-876-7535. IN WATS LINE 800-282-0224.

d. Research — We have a wealth of information that we are eager to pass on.

e. Special mailings — Up-to-the-minute information that is invaluable and justifies the high cost.

3. Education — To me this is most vital. To continue to deliver better patient care, we must first learn and then advance the art and science of medicine.

a. Accreditation of Hospital Continuing Medical Education — We have come a long way in this area and have been responsible for the accreditation of approximately 30 hospital CME programs.

b. Scientific Assembly — This is our primary opportunity to coordinate and promote the scientific programs of our specialty societies. The 1978 Scientific Assembly, held in coordination with the Southern Medical Association, hosted 2,500 physicians from the Southeast, with nearly 1,000 from Georgia.

c. Other meetings sponsored by MAG — You name it and, if it benefits our members and our patients, we will do it. To name a few: MAGNET Conference, Private Enterprise Perspectives on Medicine Seminar, Health Planning Conference, Cost Awareness Conference, Pre-Practice Seminar, etc.

4. Lobbying — State and Federal. We are successful in this area because we are fighting on behalf of our patients. Also, because of our excellent Legislative Committee and staff, along with your hard work, we have laid the foundation through candidate support with GaMPAC funds. To continue this success story, you must give your money and your time.

5. General Items — This list is virtually endless.

a. Insurance — Each year our professional liability insurance committee negotiates enough savings on the premiums to pay our MAG dues. The Membership Insurance Committee is working hard to improve other programs such as, office overhead, disability, life insurance, etc.

b. Print Shop — A real convenience to our office headquarters plus quality work at a savings to you.

c. Specialty Society Services — This is a challenge we must meet for continued unity.

d. Disabled Doctors Program — Doctors Helping Doctors — The program has treated 118 physicians and returned 77 to active practice. In truth, they represent the enrollment of a small medical school class.

B. Community Services
1. Access to Care — Our Bylaws (Section d) say it all. My goal is to increase the number of physicians in under-served areas by 10% annually. To this end, we should and can use existing clinics and programs.
2. Quality of Care — Our patients deserve our best.
a. Discipline — We must maintain the highest standards of professional conduct and adhere to the principles of medical ethics. We must tighten our belts locally as well as state-wide and continue our efforts to aid the Composite State Board of Medical Examiners.
b. Peer Review — We must make this work for better patient care as well as for protecting our peers.
c. Continuing Medical Education — Once we educate ourselves, then we can educate our patients on a continuing basis. In addition to practicing good crisis medicine, I would like to see us continue to promote preventive medicine as well. This can only be done through education.
3. Information
a. MAG Positions on Key Health Issues — A quick reference guide was compiled by MAG Past-President, Rhodes Haverty. It has proved very useful to date, and we plan to expand it. Also, cue cards are being developed on current issues and positions. These will be used to promote a positive approach for our positions.
b. Telephone Calls — Time-consuming but personal effective handling can put an irate caller on our team.
c. Letters to newspapers, editors, etc. — In addition to answering editorials, I am trying to arrange personal interviews with the editors to volunteer our source material and help. You should write, too, but always in the interest of our patients.
4. Education — To be a good teacher, first we must be a good student.
a. Public — After we have learned our lessons well, then and only then should we take on the task of educating our patients — first of all, "be prepared."
b. Schools — We must lead the way for good health measures to be taught in the early grades.
c. Patient Education — As I have said before, we can always win on our own home field, our offices and hospitals, if we will follow the Golden Rule. The best patient education is one-to-one. Pamphlets and other such material will help, but personal communication is the key to effective patient education.
5. Cost Containment — Our Cost Awareness Committee is doing an outstanding job. See for yourself. Attend the Cost Awareness Seminar at the Peachtree Plaza Hotel on August 25, 1979. Be there and educate yourself so you can have more impact on Association policy.

C. Liaison
1. Specialty Societies — To promote our mutual goals, we need to be under the big tent together. Internal dissension will destroy us. Unity will continue to make our great country number one in health care.
2. Health-Related Organizations and Groups — Here we need to face reality and discard the impossible. We must accentuate the positive and work with these groups for the benefit of our patients. I believe the pendulum is swinging in that direction.
3. Government — The HSA Task Forces were discussed at the Health Planning Conference in May 1979 and are now underway by this active committee. We suffered a great loss by the recent death of J. W. Chambers of La Grange, the loyal chairman of this committee. Nevertheless our efforts in this area will proceed.

D. Professional and Public Relations — This committee, led by Charles McDowell, has a very ambitious program. As individuals we must conduct our own doctor-patient relationship in such a manner that this committee will have something positive to communicate to the public.

E. Legislation — Another blue ribbon committee with a seasoned veteran, Jim Kaufmann, for its chairman. This committee needs our active involvement and support if

it is to effect any significant impact on health related legislation.

IV. Priorities
1. Legislation and Governmental Affairs — We have outstanding committee chairmen, staff, and committee members. They need our help, all 4,700 of us. Our record is good; we have the opportunity to make it even better.
2. Positive Public Relations — We have an excellent program, chairman, staff, and committee. Be positive and win with each patient-doctor relationship, and this program will present your fine work well.
3. Public Education — This committee, headed now by Edwin C. Evans, has come a long way during my time at MAG. It is essential that we stress the necessity of ongoing, continuing medical education to improve the art and science of medicine.
4. Membership
 a. Quantity — I know we can attain this goal.
 b. Quality — This is not only a goal we should strive for but an obligation we must meet for our patients.
5. Staff Reorganization — MAG has some of the finest staff ever since its inception 130 years ago, and I commend and thank each one for their dedication to organized medicine. We are studying staff reorganization to allow for more efficient use and better serve our members and patients.
6. MAG Headquarters Building — We are bursting at the seams and are examining the feasibility and desirability of moving our Headquarters to facilitate staff members in their service to you.

I am pleased with the results of this important meeting that enlightened us on individual staff functions, reviewed our purposes, set goals, and assigned priorities for the coming year.

Unity is our watchword, and better patient care is still number one. With your help, the Medical Association of Georgia will continue to be a respected and effective force for organized medicine.

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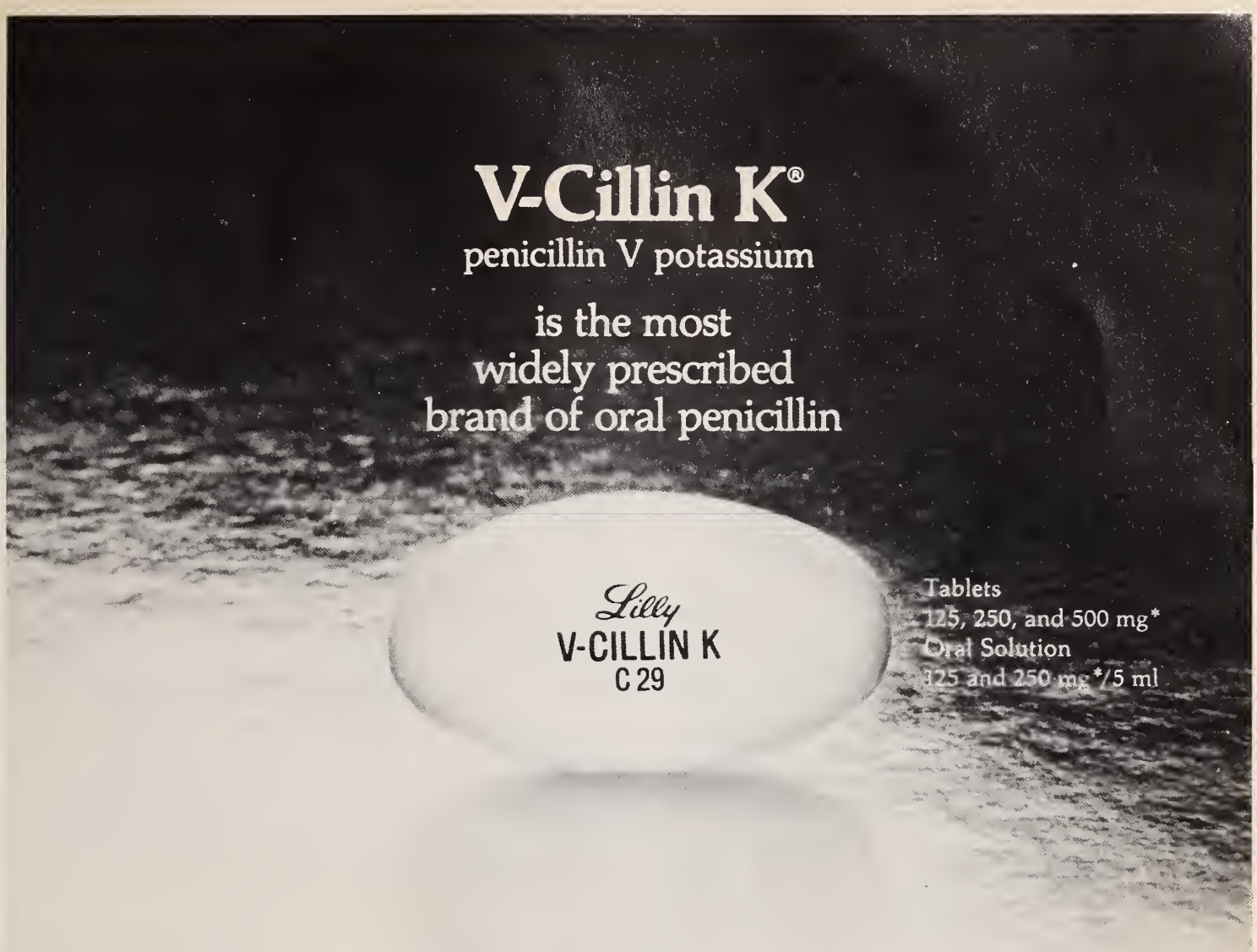
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Precautions: Use with caution in individuals with histories of significant allergies and/or asthma. Do not rely on oral administration in patients with severe illness, nausea, vomiting, gastric dilatation, cardiospasm, or intestinal hypermotility. Occasional patients will not absorb therapeutic amounts given orally. In streptococcal infections, treat until the organism is eliminated (minimum of ten days). With prolonged use, nonsusceptible organisms, including fungi, may overgrow; treat superinfection appropriately.

Adverse Reactions: Hypersensitivity, including fatal anaphylaxis. Nausea, vomiting, epigastric distress, diarrhea, and black, hairy tongue. Skin eruptions, urticaria, reactions resembling serum sickness (including chills, edema, arthralgia, prostration), laryngeal edema, fever, and eosinophilia. Infrequent hemolytic anemia, leukopenia, thrombocytopenia, neuropathy, and nephropathy, usually with high doses of parenteral penicillin. 1102175

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TRIAVIL is contraindicated in CNS depression from drugs, in the presence of evidence of bone marrow depression, and in patients hypersensitive to phenothiazines or amitriptyline. It should not be used during the acute recovery phase following myocardial infarction or in patients who have received an MAOI within two weeks. Patients with cardiovascular disorders should be watched closely. Not recommended in children or during pregnancy. TRIAVIL may impair mental and/or physical abilities required for performance of hazardous tasks and may enhance the response to alcohol. Antiemetic effect may obscure toxicity due to overdosage of other drugs or mask other disorders. The possibility of suicide in depressed patients remains until significant remission occurs. Such patients should not have access to large quantities of the drug. Hospitalize as soon as possible any patient suspected of having taken an overdose.

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Please see following page for a brief summary of prescribing information.

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TRIAVIL® 4-25: Each tablet contains
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TRIAVIL® 4-10: Each tablet contains
4 mg perphenazine and 10 mg amitriptyline HCl.

CONTRAINDICATIONS: Central nervous system depression from drugs (barbiturates, alcohol, narcotics, analgesics, antihistamines); evidence of bone marrow depression; known hypersensitivity to phenothiazines or amitriptyline. Should not be given concomitantly with a monoamine oxidase inhibitor since hyperpyretic crises, severe convulsions, and deaths have occurred from such combinations. When used to replace a monoamine oxidase inhibitor, allow a minimum of 14 days to elapse before initiating therapy with TRIAVIL. Therapy should then be initiated cautiously with gradual increase in dosage until optimum response is achieved. Not recommended for use during acute recovery phase following myocardial infarction.

WARNINGS: TRIAVIL should not be given concomitantly with guanethidine or similarly acting compounds since TRIAVIL may block the antihypertensive action of such compounds. Use cautiously in patients with history of urinary retention, angle-closure glaucoma, increased intraocular pressure, or convulsive disorders. Dosage of anticonvulsive agents may have to be increased. In patients with angle-closure glaucoma, even average doses may precipitate an attack. Patients with cardiovascular disorders should be watched closely. Tricyclic antidepressants, including amitriptyline HCl, have been reported to produce arrhythmias, sinus tachycardia, and prolongation of conduction time, particularly in high doses. Myocardial infarction and stroke have been reported with tricyclic antidepressant drugs. Close supervision is required for hyperthyroid patients or those receiving thyroid medication. May impair mental and/or physical abilities required for performance of hazardous tasks, such as operating machinery or driving a motor vehicle. In patients who use alcohol excessively, potentiation may increase the danger inherent in any suicide attempt or overdosage. Not recommended in children or during pregnancy.

PRECAUTIONS: Suicide is a possibility in depressed patients and may remain until significant remission occurs. Such patients should not have access to large quantities of this drug.

Perphenazine: Should not be used indiscriminately. Use with caution in patients who have previously exhibited severe adverse reactions to other phenothiazines. Likelihood of some untoward actions is greater with high doses. Closely supervise with any dosage. The antiemetic effect of perphenazine may obscure signs of toxicity due to overdosage of other drugs or make more difficult the diagnosis of disorders such as brain tumor or intestinal obstruction. A significant, not otherwise explained, rise in body temperature may suggest individual intolerance to perphenazine, in which case discontinue.

If hypotension develops, epinephrine should not be employed, as its action is blocked and partially reversed by perphenazine. Phenothiazines may potentiate the action of central nervous system depressants (opiates, analgesics, antihistamines, barbiturates, alcohol) and atropine. In concurrent therapy with any of these, TRIAVIL should be given in reduced dosage. May also potentiate the action of heat and phosphorous insecticides. There is sufficient experimental evidence to conclude that chronic administration of antipsychotic drugs which increase prolactin secretion has the potential to induce mammary neoplasms in rodents under the appropriate conditions. There are recognized differences in the physiological role of prolactin between rodents and humans. Since there are, at present, no adequate epidemiological studies, the relevance to human mammary cancer risk from prolonged exposure to perphenazine and other antipsychotic drugs is not known.

Amitriptyline: In manic-depressive psychosis, depressed patients may experience a shift toward the manic phase if they are treated with an antidepressant. Patients with paranoid symptomatology may have an exaggeration of such symptoms. The tranquilizing effect of TRIAVIL seems to reduce the likelihood of this effect. When amitriptyline HCl is given with anticholinergic agents or sympathomimetic drugs, including epinephrine combined with local anesthetics, close supervision and careful adjustment of dosages are required. Paralytic ileus may occur in patients taking tricyclic antidepressants in combination with anticholinergic-type drugs.

Caution is advised if patients receive large doses of ethchlorvynol concurrently. Transient delirium has been reported in patients who were treated with 1 g of ethchlorvynol and 75-150 mg of amitriptyline HCl.

Amitriptyline HCl may enhance the response to alcohol and the effects of barbiturates and other CNS depressants.

Concurrent administration of amitriptyline HCl and electroshock therapy may increase the hazards associated with such therapy. Such treatment should be limited to patients for whom it is essential. Discontinue several days before elective surgery if possible. Elevation and lowering of blood sugar levels have both been reported. Use with caution in patients with impaired liver function.

ADVERSE REACTIONS: Similar to those reported with either constituent alone.
Perphenazine: Extrapyramidal symptoms (opisthotonus, oculogyric crisis, hyperreflexia, dystonia, akathisia, acute dyskinesia, ataxia, parkinsonism) have been reported and can usually be controlled by the concomitant use of effective antiparkinsonian drugs and/or by reduction in dosage, but sometimes persist after discontinuation of the phenothiazine.

Tardive dyskinesia may appear in some patients on long-term therapy or may occur after drug therapy with phenothiazines and related agents has been discontinued. The risk appears to be greater in elderly patients on high-dose therapy, especially females. Symptoms are persistent and in some patients appear to be irreversible. The syndrome is characterized by rhythmical involuntary movements of the tongue, face, mouth, or jaw. Involuntary movements of the extremities sometimes occur. There is no known treatment for tardive dyskinesia; antiparkinsonism agents usually do not alleviate the symptoms. It is advised that all antipsychotic agents be discontinued if the above symptoms appear. If treatment is reinstituted, or dosage of the particular drug increased, or another drug substituted, the syndrome may be masked. Fine vermicular movements of the tongue may be an early sign of the syndrome. The full-blown syndrome may not develop if medication is stopped when lingual vermiculation appears.

Other side effects are skin disorders (photosensitivity, itching, erythema, urticaria, eczema, up to exfoliative dermatitis); other allergic reactions (asthma, laryngeal edema, angioneurotic edema, anaphylactoid reactions); peripheral edema; reversed epinephrine effect; hyperglycemia; endocrine disturbances (lactation, galactorrhea, gynecomastia, disturbances of menstrual cycle); altered cerebrospinal fluid proteins; paradoxical excitement; hypertension, hypotension, tachycardia, and ECG abnormalities (quinidine-like effect); reactivation of psychotic processes; catatonic-like states; autonomic reactions, such as dry mouth or salivation, headache, anorexia, nausea, vomiting, constipation, obstipation, urinary frequency or incontinence, blurred vision, nasal congestion, and a change in pulse rate; other adverse reactions reported with various phenothiazine compounds, but not with perphenazine, include grand mal convulsions, cerebral edema, polyphagia, pigmentary retinopathy, photophobia, skin pigmentation, and failure of ejaculation.

The phenothiazine compounds have produced blood dyscrasias (pancytopenia, thrombocytopenic purpura, leukopenia, agranulocytosis, eosinophilia); and liver damage (jaundice, biliary stasis).

Pigmentation of the cornea and lens has been reported to occur after long-term administration of some phenothiazines. Although it has not been reported in patients receiving TRIAVIL, the possibility that it might occur should be considered.

Hypnotic effects, lassitude, muscle weakness, and mild insomnia have also been reported.

Amitriptyline: Note: Listing includes a few reactions not reported for this drug, but which have occurred with other pharmacologically similar tricyclic antidepressant drugs and must be considered when amitriptyline is administered. *Cardiovascular:* Hypotension; hypertension; tachycardia; palpitation; myocardial infarction; arrhythmias; heart block; stroke. *CNS and Neuromuscular:* Confusional states; disturbed concentration; disorientation; delusions; hallucinations; excitement; anxiety; restlessness; insomnia; nightmares; numbness, tingling, and paresthesias of the extremities; peripheral neuropathy; incoordination; ataxia; tremors; seizures; alteration in EEG patterns; extrapyramidal symptoms; tinnitus; syndrome of inappropriate ADH (antidiuretic hormone) secretion. *Anticholinergic:* Dry mouth; blurred vision; disturbance of accommodation; increased intraocular pressure; constipation; paralytic ileus; urinary retention; dilatation of urinary tract. *Allergic:* Skin rash; urticaria; photosensitization; edema of face and tongue. *Hematologic:* Bone marrow depression including agranulocytosis; leukopenia; eosinophilia; purpura; thrombocytopenia. *Gastrointestinal:* Nausea; epigastric distress; vomiting; anorexia; stomatitis; peculiar taste; diarrhea; parotid swelling; black tongue. Rarely hepatitis (including altered liver function and jaundice). *Endocrine:* Testicular swelling and gynecomastia in the male; breast enlargement and galactorrhea in the female; increased or decreased libido; elevated or lowered blood sugar levels. *Other:* Dizziness, weakness; fatigue; headache; weight gain or loss; increased perspiration; urinary frequency; mydriasis; drowsiness; alopecia. *Withdrawal Symptoms:* Abrupt cessation after prolonged administration may produce nausea, headache, and malaise. These are not indicative of addiction.

OVERDOSAGE: All patients suspected of having taken an overdosage should be admitted to a hospital as soon as possible. Treatment is symptomatic and supportive. However, the intravenous administration of 1–3 mg of physostigmine salicylate is reported to reverse the symptoms of tricyclic antidepressant poisoning. Because physostigmine is rapidly metabolized, the dosage of physostigmine should be repeated as required particularly if life-threatening signs such as arrhythmias, convulsions, and deep coma recur or persist after the initial dosage of physostigmine. On this basis, in severe overdosage with perphenazine-amitriptyline combinations, symptomatic treatment of central anticholinergic effects with physostigmine salicylate should be considered.

J8TR31 (DC6613215)

For more detailed information, consult your MSD Representative or see full Prescribing Information. Merck Sharp & Dohme, Division of Merck & Co., INC., West Point, Pa. 19486.

MSD
MERCK SHARP & DOHME

A Resolution from the Troup County Medical Society—RE: Dr. Ruben Shirley O'Neal

WHEREAS: Dr. Ruben Shirley O'Neal, who died April 10, 1979, at the West Georgia Medical Center, in LaGrange, Georgia, was born in Harris County, Georgia, on the 1st of September, 1886, near Jones Crossroads, attended grade school at Harris County and high school at the Jessie Williams Institute in Harris County, attended medical college at the Atlanta Medical College in Atlanta, and graduated from the University of Georgia College of Medicine in Augusta in 1911, and in 1913 married Leila Williams, who was a graduate nurse and who preceded him in death, and to whom their son Howard was born, and:

WHEREAS: Dr. Ruben O'Neal first practiced medicine in West Point, Georgia, then moved to Bronwood, Georgia, thence to Buena Vista, Georgia, before volunteering for military service in World War I where he was assigned to the British Army and went overseas and from which he was separated in 1919 and moved to LaGrange where he resided continuously until his death, and;

WHEREAS: Dr. O'Neal was active in civic affairs having organized the LaGrange Lions Club and was its charter president, was a member of the Chamber of Commerce, active in church work and a member of the First Baptist Church for over 60 years, active in political life, serving on LaGrange City Council in 1923-24, and as Mayor of LaGrange from 1934 to 1950, and in financial affairs served on the Boards of Directors of Citizens & Southern Bank and First Federal Savings & Loan, and;

WHEREAS: Dr. "Rube" practiced medicine continuously for 68 years having been a charter member and held all offices in the Troup County Medical Society, was a member of the District Society, the Medical Association of Georgia, and the American Medical Association, received his 50-year service award from the Medical Association of Georgia in 1961, and Dr. "Rube" was honored and greatly pleased when in 1969 he was nominated for and received recognition as the "General Practitioner of the Year" of the Medical Association of Georgia, and Dr. "Rube" was one of the key men in the building of the City-County Hospital which has now grown into the West Georgia Medical Center, when as a member of the staff and as Mayor of LaGrange he was a driving force in securing city, county, and federal money for the hospital construction, and at his death was one of the very few surviving members of the original hospital staff, and;

WHEREAS: Dr. "Rube" was the oldest active medical doctor practicing in the State of Georgia at the time of his death, and in keeping with his life-long habit of using work as the treatment for his own ailments, regularly went to his office daily, 6 days per week, drove his car to work, saw patients, realized that this time he was too sick to "carry on," drove his car home alone and finally consented to be hospitalized that day, and succumbed to an incredible number of ailments 10 days later in almost full possession of his mental faculties until his death,

THEREFORE: Be it resolved that this resolution, expressing this society's deep regard for its old and dear friend make this resolution a permanent part of its minutes and send a copy of it to his family expressing our deep regard for Dr. "Rube" and our sense of loss at his death. Dr. "Rube" will be greatly missed by those of us who knew him well, but to use his favorite expression, we will "just have to go along," without him.

May God bless him and keep him busy.

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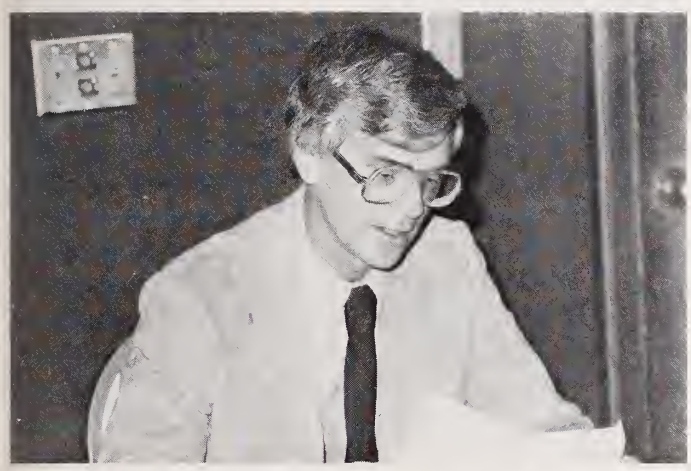
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Francis (Bill) Rushing, Ph.D., Associate Professor of Economics at Georgia State University, leads a discussion of, "Is There a Right to Health Care?"



Craig Aronoff, Ph.D., Professor of Management and Communications at Georgia State University, leads a small group discussion on medical advertising.

Medicine and the Economic System

A Summary Report of MAG's PEP Seminar

The Medical Association of Georgia's PEP Seminar — "*P*rivate *E*nterprise *P*erspectives on Medicine" — provided a unique opportunity for dialogue on and insight into some of the key issues of our day. Sixty people, including 41 physicians, met at the Colony Square Hotel in Atlanta on May 26-27, 1979, to hear faculty from Georgia State University (GSU) talk about the place of medicine in the American economic system. The participants had their say, too, in both large and small group discussions, where they debated such subjects as the profit motive, soaring medical costs, national health insurance, competition, advertising, public pressure, and big government. As one participant put it, the seminar was a "good forum for discussion between polarized groups who found that their differences weren't as great as they thought." In the words of another, the meeting "brought a group of physicians together to discuss an item of vital importance to them — the slowing eroding private enterprise [system] and the real concerns of many patients of rising costs and financial disaster."

The seminar's principal speakers were Craig E. Aronoff, Ph.D., Assistant Professor of Management and Communications at GSU; and Francis W. Rushing, Ph.D., Associate Professor of Economics at GSU. Both made penetrating observations and raised provocative questions about the economics of medicine.

Professor Aronoff described a hamstrung medical marketplace which does not respond well to change. In what Aronoff referred to as the medical "industry," the price of goods and services is directly proportional to the supply of these goods and services — just the reverse of most industries. The business community, organized labor, government, and the public have been bringing increasing pressure on the medical profession because of the high costs of care. This pressure typically manifests itself in support for a program of national health insurance. According to Aronoff, society is trying to take action against the medical profession as a whole because it perceives it as overstepping its bounds. On its side, the medical profession has few countervailing measures to keep costs low. Competition would be the most powerful measure; and alternative counterpressures are the developing HMOs and for-profit hospitals, where there is an incentive to contain costs.

Professor Rushing pointed out that the medical profession is an exception because it is not competitive and because its goods and services are delivered in circumstances which to the consumer are unpredictable, out-of-the-ordinary, and uncertain. Health insurance is an attempt to deal with the risk of the economic consequences of illness; but the third party payment system encourages increased demand for care by the insured, with little or no incentive to contain costs. Thus, those crying loudest about medical costs are often guilty of making the costs rise. To further complicate matters, physicians tend to consider it a moral obligation to render the highest quality of care regardless of cost. People expect physicians not to behave as profit-seeking businessmen, and the ''trust'' relationship between doctor and patient has generated economic problems for a profession that is also a service industry.

To give focus to specific problems raised by Professors Aronoff and Rushing, participants divided into five discussion groups to try to reach a consensus on some solutions. Following are the summaries of those discussions:

HMOs: As a prepaid method of transferring the costs of medical services, the ''health maintenance organization'' is a misnomer: it does not really maintain health. The public needs to be educated about what an HMO is and how it is a part of the American free enterprise system. There has been a lot of pressure from non-government groups, such as labor, to set up some kind of HMO; and physicians would do well to consider the various models of HMO. The most attractive model would appear to be the Individual Practice Association (IPA), which allows the physician to provide services with a minimum of governmental intrusion. HMOs introduce an element of competition into the medical marketplace, and this is good up to the point of involvement by the government. It was felt that the patient enrolled in an HMO should pay according to risk; this is sometimes referred to as ''experience rating.''

The Supply and Distribution of Medical Services: The development of health systems agencies (HSAs) represents a part of the consumer movement to be involved in the planning of supply and distribution of goods and services. Although there is undoubtedly a problem of adequate distribution of medical care providers to certain areas in Georgia and the nation, it is difficult to determine what the appropriate number of physicians is for any given area. A surplus of health care providers will not necessarily make them go to underserved areas. Here, as with other sectors of the economy, economic realities affect the distribution of manpower.



MAG members and spouses take a break at the PEP Seminar.

It may be necessary for a given town or locality to revitalize itself economically before it can attract a physician or additional physician(s). In deciding which direction to take in the supply and distribution of medical services, the basic choice is between a health planning model and an open market model. The oversupply of sub-specialists in medicine and surgery might be corrected by cutting funding for residency programs in the sub-specialties.

Medicaid Reimbursement in Georgia: Reimbursement for services is desirable and necessary for the provider of medical care, and such reimbursement should come from both the private and public sectors. There are many inadequacies and inequities in the present Medicaid reimbursement system in Georgia. One problem is that reimbursement fees for primary care physicians in rural areas are lower than those for other physicians. Another problem is the inequity of ineligible Medicaid recipients abusing the program. A third problem is the inflexibility of the program and the red tape involved in the turnaround time for the payment of claims.

Advertising: Medical advertising will become a reality for the medical community, and such advertising is acceptable as long as it is truthful. It should be the responsibility of the local medical community to monitor the truthfulness. In response to the question of whether physicians should advertise the quality or price of medical care, it is the consensus that individual patients should be left to ascertain prices by personally contacting physicians. While advertising in printed media is appropriate, television advertising is considered to be inappropriate. A medical advertisement may typically contain the physician's credentials, training, specialty, hospital affiliation, office hours, and any foreign language spoken. Local medical societies may publish directories of physicians which include prices of basic services, the doctor's name, location, specialty, spe-



MAG participants listen to a presentation at a plenary session of the PEP Seminar on May 26.

cial services and interest, hours, credentials, hospital affiliation, foreign language (if spoken), method of payment, types of patients accepted, as well as other pertinent information. It is the responsibility of organized medicine to pursue and identify with vigor any fraudulent advertising to the public.

Is There a Right to Health Care? A careful definition of this question seems to be a requirement in order to answer it properly. The study group saw the meaning of "a right" as used here to be critical. The group agreed that a right must be a very basic claim to a condition which is indispensable to a good life for the individual, and that it must be grounded in values and ethics, not merely political opportunism. It was agreed, too, that certain rights have priority and precedence by their sanction in the constitution, in long accepted practice, in law, and in religion.

Health was viewed as a value so basic to many other values that it would seem to be a condition of good life, the restoration of which is the historic and continuing goal of the physician and other health professionals. No obstacle should be placed to one's free pursuit of health, to one's choice of health measures, or to one's free association with health professionals of his choice. It is the obligation and responsibility of the individual to see to his own health in ways of his own choice.

Health care by professionals is one method for preserving or restoring health. It can take many forms, including medical treatment, varying with individual needs and preferences and circumstances. Individual preferences are too varied for there to be any meaningful guarantee of health care by the agency of the state. The attempt would lead to inevitable disparity and discrimination, as the state would necessarily have to endorse one kind of health care, excluding others. Such is a political decision to use economic resources, a choice which sharply limits the citizen's freedom to make decisions in his own health interest. Thus, health care provided by political methods carries an inherent contradiction in that it severely limits the individual's prior right to choose his own approach to health care.

There is no constitutional right to health care, though there are freedoms which are clearly stated in the Constitution.

There is no right to health care in medical ethics, though there are stated obligations to serve patients who have entered a free contract with a physician.

There is no right to health care in tradition or precedent.

There is no right to health care based in religious teachings.

Those politicians who claim that health care is a right which the state should guarantee are unfounded in their claim. Economic and political choices can be legislated, but this must occur on some other basis than "a right to health care." Political decisions must meet constitutional tests of equity and justice and economic tests of utility and feasibility. Is it just to tax people to support one form of health care? Is it just to exclude other forms? Is it not better practice to permit diverse approaches to health care, to meet individual needs and to discover improvements, though these diverse approaches would clearly not be equal? Can the country afford the cost of a full range of health care measures? Should it? These profound questions must be answered on their own merit. The search for answers should not be confused by spurious claims of "a right to health care."

MAG Encourages Involvement in Physicians Task Forces

At its 1979 meeting, the MAG House of Delegates voted to "continue to stimulate widespread physician interest in health planning through Physicians Task Forces or whatever other means the physicians in each health service area deem appropriate for their health systems agency (HSA)." The House also "encouraged physicians already on HSA Boards to become more active in the activities of their respective HSAs and to encourage other physicians to become active in their local HSA." This was done in response to the recommendations of the Committee on Health Planning, chaired by the late Dr. J. W. Chambers of LaGrange. The committee is now organizing several of these HSA/Physicians Task Forces throughout the state.

U. S. ARMY MEDICAL DEPARTMENT

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GENERAL

The Army Medical Department (AMEDD) represents the largest comprehensive system of health care in the United States. Within one centrally directed system, the medical disciplines of patient care, preventive medicine, research, education, and administration are coordinated to provide a unified system of health care for approximately three and one-half million people including Active Army personnel, their dependents, as well as retired military personnel and their dependents.

During the summer of 1980, the Army is offering a large number of First Year Graduate Medical Education (FYGME) positions. Previously, most positions were filled by participants in the US Army Health Professions Scholarship Program (HPSP). However, for training beginning in July 1980, the Army will be actively seeking qualified civilian applicants who have no current Army affiliation.

DESCRIPTION

Army medical training programs are among the best in the nation. All are approved by the Liaison Committee on Graduate Medical Education of the American Medical Association. Virtually all recognized residencies are offered. Most Army training facilities are affiliated with a medical school. Medical centers and hospitals are well equipped with laboratory, medical, surgical, radiological, library and other requisite facilities. Medical records keeping is excellent.

All patients are available as teaching patients. The range of cases, both in age and complexity, is virtually impossible to duplicate. Because of the scope of the Army's activities and its highly sophisticated evacuation system, you will have the chance to see and study diseases you would never encounter in most programs. Furthermore, you have no worry about your patient's ability to pay.

The following Army FYGME programs are offered:

(1) **Flexible.** The flexible FYGME program is designed as a year of broad medical education prior to pursuing a specialized residency or as a program for individuals as yet undecided about further specialization. Four months of medicine are required in this program along with additional requirements and electives that vary slightly from teaching center to teaching center.

(2) **Categorical.** Categorical programs are offered in medicine, surgery, obstetrics/ gynecology, pathology, pediatrics, physical medicine, and family practice. The majority of the 12 month period is spent on the service concerned or in related areas and is considered by most of the appropriate specialty boards as the first year of residency training.

(3) **Categorical diversified.** These programs are essentially a combination of the above two and are offered in radiology, psychiatry, neurology, and anesthesiology. The primary emphasis is upon the major specialty with additional required and elective rotations on other services.

To find out more information concerning this program, the eligibility criteria, service obligation, benefits and application procedures contact the AMEDD Personnel Counselor serving your area.

Deadline for applications is **1 September 1979.** All applicants are encouraged to also participate in the NIRMP. Sections for the Army FYGME Program will be announced in sufficient time for selectees to withdraw from the NIRMP.

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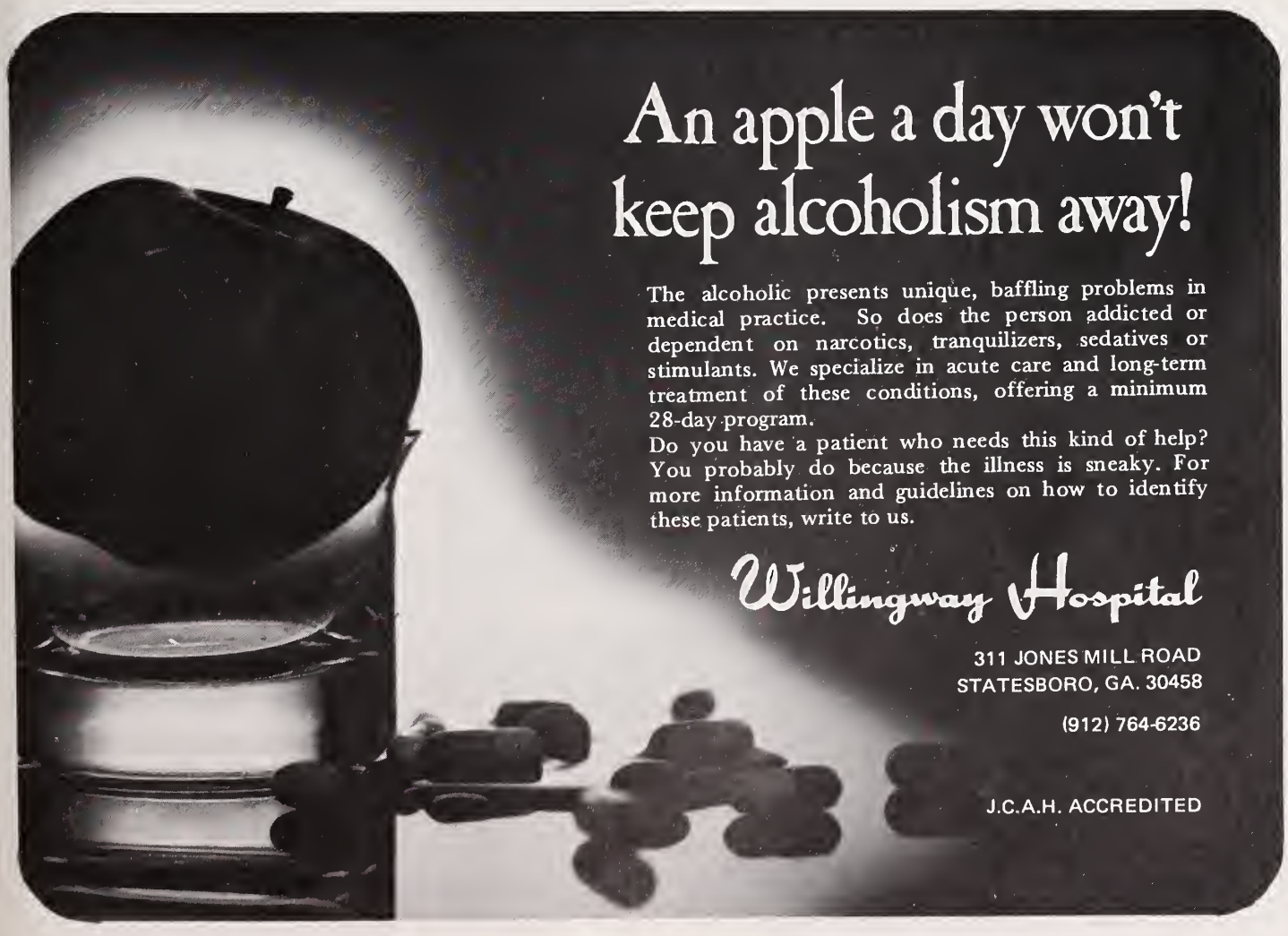
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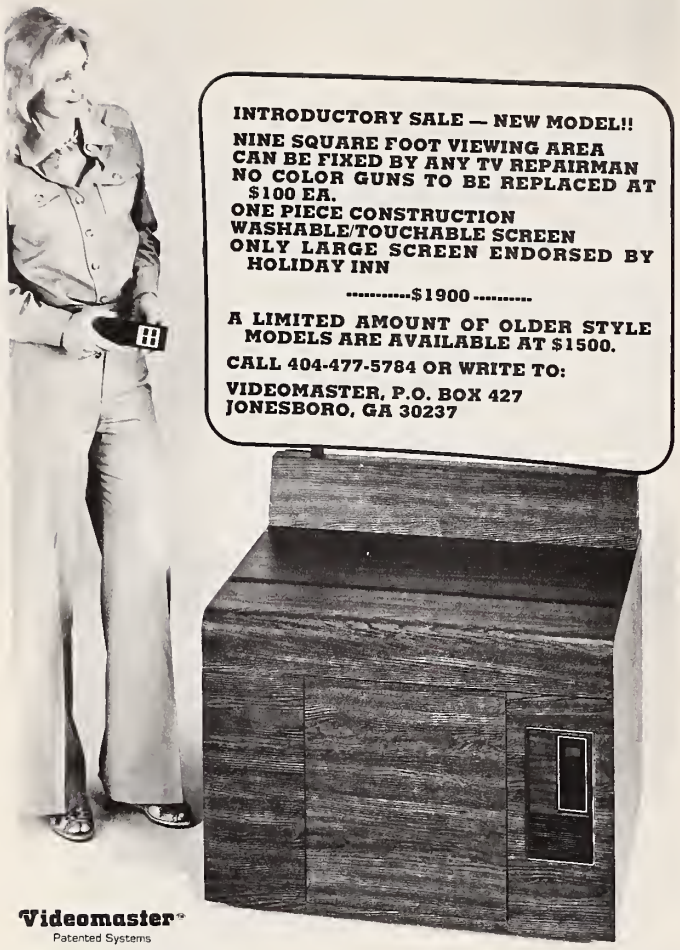
The Physicians' Current Procedural Terminology, Fourth Edition (CPT-IV), published by the AMA, is a listing of descriptive terms and identifying five-digit codes for reporting medical services and procedures performed by physicians. The purpose of the terminology is to provide a uniform language that will accurately designate medical, surgical, and diagnostic services. For convenience, the layout is divided into procedures relating to medicine, surgery, radiology, pathology, etc., but any procedure may be used to designate services provided by any qualified physician.

The Health Care Finance Administration has adopted the new International Classification of Disease (ICD-9) diagnostic and procedure codes for hospital use in government programs. It is now evident that the AMA CPT will be the standard for physicians' services. Medicaid has been using the CPT coding process for some time. Medicare (Prudential, Part B) now encourages physicians to code their services with the CPT. Blue Shield of Columbus voted at its February 1979 meeting to convert to this coding system. Blue Shield of Atlanta has not yet made a decision to change.

The 1979 MAG House of Delegates passed a recommendation from the MAG Third Party Relations Committee to adopt the CPT-IV. Coding your procedures by this system will give third party carriers a precise definition of the services which you provide and speed up processing time for payments. It will also prevent errors in coding which result in erroneous payments and will simplify completion of forms, since you will need to use only the one coding system. To deal with those agencies which do not accept the codes of the CPT, it is still suggested that you use the terminology of this system to identify the procedure performed.

For these reasons, the MAG encourages you to use the AMA CPT-IV for your procedure coding. Copies may be obtained from the Order Department, OP-41, American Medical Association, P.O. Box 821, Monroe, Wisconsin 53566, at a cost of $12.00 each.





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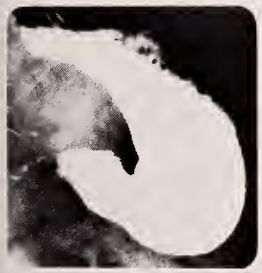
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†See Warnings, Precautions and Adverse Reactions.

See following page for prescribing information.

Reference:
King, J.C. and Starkman, N.M.: Evaluation of an antispasmodic. Double-blind evaluation to control gastrointestinal spasms occurring during radiographic examination. A preliminary report. Western Med. 5:356-358, 1964.

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Brief Summary

INOICATIONS

Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FOA has classified the following indications as "probably" effective

For the treatment of functional bowel/irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis.

THESE FUNCTIONAL DISORDERS ARE OFTEN RELIEVED BY VARYING COMBINATIONS OF SEDATIVE, REASSURANCE, PHYSICIAN INTEREST, AMELIORATION OF ENVIRONMENTAL FACTORS.

For use in the treatment of infant colic (syrup).

Final classification of the less-than-effective indications requires further investigation.

CONTRAINOICATIONS: Obstructive uropathy (for example, bladder neck obstruction due to prostatic hypertrophy); obstructive disease of the gastrointestinal tract (as in achalasia, pyloroduodenal stenosis); paralytic ileus, intestinal atony of the elderly or debilitated patient; unstable cardiovascular status in acute hemorrhage; severe ulcerative colitis; toxic megacolon complicating ulcerative colitis; myasthenia gravis. WARNINGS: In the presence of a high environmental temperature, heat prostration can occur with drug use (fever and heat stroke due to decreased sweating). Diarrhea may be an early symptom of incomplete intestinal obstruction, especially in patients with ileostomy or colostomy. In this instance treatment with this drug would be inappropriate and possibly harmful. Bentyl may produce drowsiness or blurred vision. In this event, the patient should be warned not to engage in activities requiring mental alertness such as operating a motor vehicle or other machinery or perform hazardous work while taking this drug. PRECAUTIONS: Although studies have failed to demonstrate adverse effects of dicyclomine hydrochloride in glaucoma or in patients with prostatic hypertrophy, it should be prescribed with caution in patients known to have or suspected of having glaucoma or prostatic hypertrophy. Use with caution in patients with: Autonomic neuropathy. Hepatic or renal disease. Ulcerative colitis. Large doses may suppress intestinal motility to the point of producing a paralytic ileus and the use of this drug may precipitate or aggravate the serious complication of toxic megacolon. Hyperthyroidism, coronary heart disease, congestive heart failure, cardiac arrhythmias, and hypertension. Hiatal hernia associated with reflux esophagitis since anticholinergic drugs may aggravate this condition.

Do not rely on the use of the drug in the presence of complication of biliary tract disease. Investigate any tachycardia before giving anticholinergic (atropine-like) drugs since they may increase the heart rate. With overdosage, a curare-like action may occur. ADVERSE REACTIONS: Anticholinergics/antispasmodics produce certain effects which may be physiologic or toxic depending upon the individual patient's response. The physician must delineate these. Adverse reactions may include xerostomia; urinary hesitancy and retention; blurred vision and tachycardia; palpitations; mydriasis; cycloplegia; increased ocular tension; loss of taste; headache; nervousness; drowsiness; weakness; dizziness; insomnia; nausea; vomiting; impotence; suppression of lactation; constipation; bloated feeling; severe allergic reaction or drug idiosyncrasies including anaphylaxis; urticaria and other dermal manifestations; some degree of mental confusion and/or excitement, especially in elderly persons; and decreased sweating. With the injectable form there may be a temporary sensation of lightheadedness and occasionally local irritation. OOSAGE ANO AOMINISTRATION: Oosage must be adjusted to individual patient's needs.

Usual Oosage: Bentyl 10 mg. capsule and syrup: *Adults:* 1 or 2 capsules or teaspoonfuls syrup three or four times daily. *Children:* 1 capsule or teaspoonful syrup three or four times daily. *Infants:* ½ teaspoonful syrup three or four times daily. (May be diluted with equal volume of water.) Bentyl 20 mg.: *Adults:* 1 tablet three or four times daily. Bentyl Injection: *Adults:* 2 ml. (20 mg.) every four to six hours intramuscularly only. NOT FOR INTRAVENOUS USE. MANAGEMENT OF OVEROOSE: The signs and symptoms of overdose are headache, nausea, vomiting, blurred vision, dilated pupils, hot, dry skin, dizziness, dryness of the mouth, difficulty in swallowing, CNS stimulation. Treatment should consist of gastric lavage, emetics, and activated charcoal. Barbiturates may be used either orally or intramuscularly for sedation but they should not be used if Bentyl with Phenobarbital has been ingested. If indicated, parenteral cholinergic agents such as Urecholine® (bethanecol chloride USP) should be used.

Product Information as of October, 1978.

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938 Peachtree Street, NE / Atlanta, Georgia 30309

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NEWS NOTES — District and county medical societies, Association members, and readers are invited to send in any news items of general concern to members of the Medical Association of Georgia.

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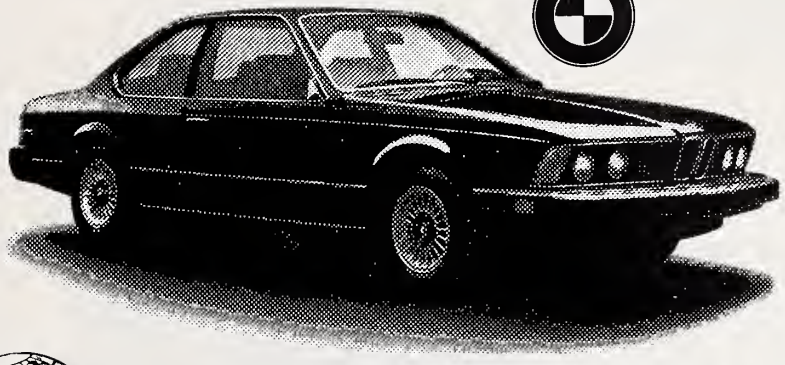
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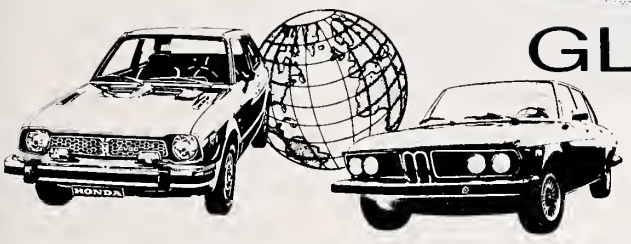
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The Maker

Examining a Few Myths About Prescribing.



Increasing pressure is being put on the practicing physician to prescribe drugs generically. You are told that brand–name products are universally "expensive" and generic versions are relatively "cheap." To make this case, the most extreme (rather than typical) price differentials are cited. Thus, consumers are led to believe that such differentials are commonplace. Even your knowledge and your motives as a physician are questioned.

Understandably, these views have created myths. We think it's time to examine them in the light of all the facts and ramifications.

MYTH: There are no differences in quality and performance between brand-name products and their generic counterparts. The corollary is that there are no differences among products made by high-technology, quality-conscious, research-based companies and those made by commodity-type suppliers.

FACT: The Food and Drug Administration does a good job in monitoring a generally excellent drug supply. Still, it has nowhere near the resources to guarantee the quality and bioavailability of all marketed products at any given time. Just a few months ago, for example, it noted that batches of tetracycline HCl capsules which met official monograph requirements were not bioequivalent to a reference product. As y know, there is substan literature on this subje affecting many drugs, i cluding such antibioti as tetracycline and ery thromycin. The record drug recalls and court actions affirms strongl that there are differenc among pharmaceutica companies and their products. Research-intensive companies have far better records than those that do no r search and may practi minimum quality assu ance.

MYTH: Industry favors only "expensive" brand names and denigrates al generics.

FACT: PMA companie make 90 to 95 percent the drug supply, includ ing, therefore, most of generics. Drug nomen clature is not the impo tant point; it's the com tence of the manufac- turer and the integrity the product that count

Matters.

*TH: Generic options al-
t always exist.*

**CT: About 55 percent
rescription drug ex-
diture is for single-
rce drugs. This
ans, of course, that for
45 percent of such
enditure, is a generic
scribing option avail-
e.**

*TH: Generic
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pensive generics, thus
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s of money.*

**CT: Market data show
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rces, in the best inter-
of patients. In most
es the patient receives
oven brand product.
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ggerated.**

MYTH: Drugs account for a major portion of the rise in health care costs.

FACT: Drugs represent a very small part of such costs. The amount of the health care dollar spent for prescription drugs was about 12 cents in 1967; today it is about 8 cents. And you as a physician are most conscious of how drug therapy can cut hospitalization, avert surgery, reduce office visits and keep patients on the job.

MYTH: Government intrusions into the marketplace will save tax money.

FACT: Government schemes always cost the taxpayer something, and the costs often exceed the benefits. Certainly, any federal "help," such as lists of wholesale drug prices sent to all physicians and pharmacists, will be no exception. Just think of the expense of keeping them current! Moreover, wholesale prices are poor guides to actual transaction prices and even worse guides to retail prices.

The PMA Position

We believe your freedom to prescribe, either by generic or brand name, should be totally unabridged. Otherwise, your prescribing prerogatives and your relationships with patients will be seriously impaired.

The maker does matter

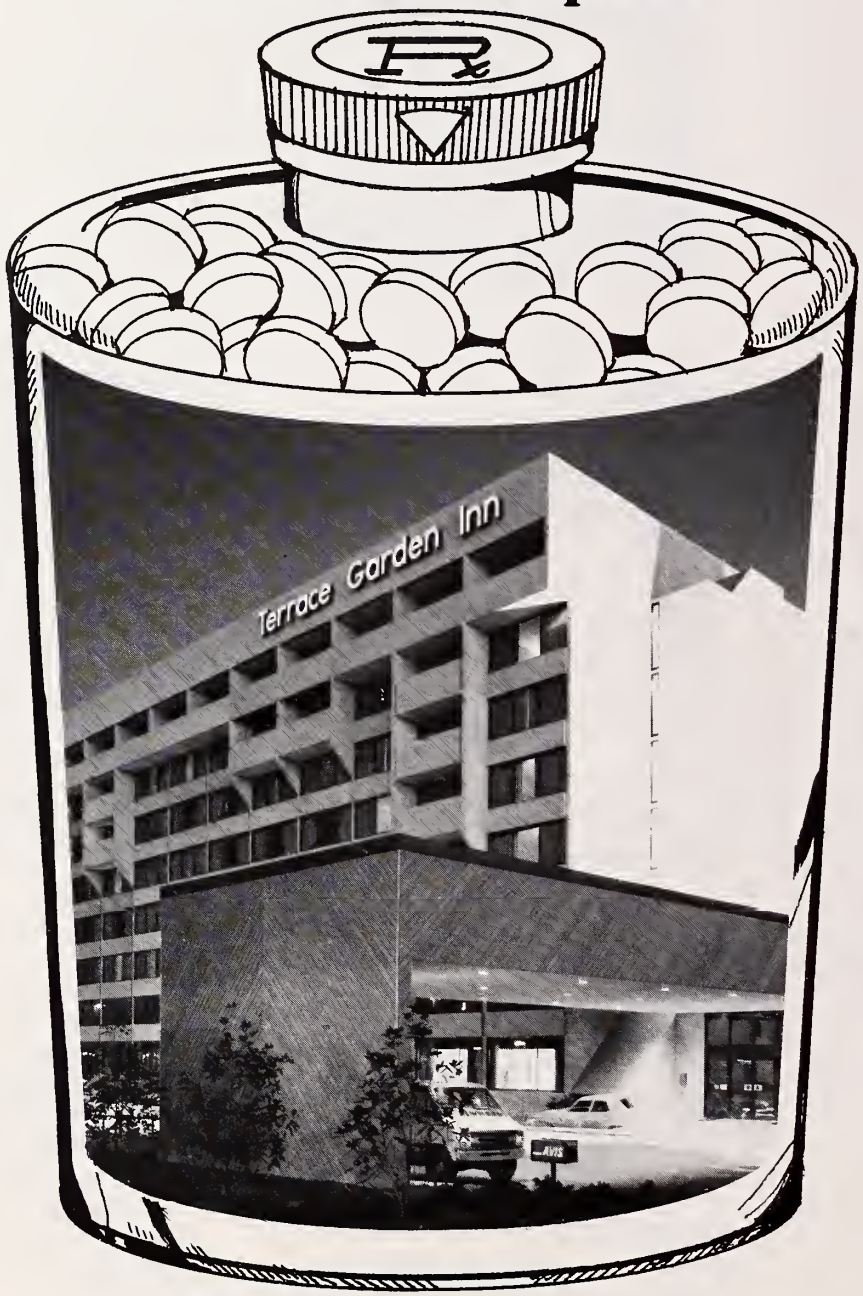
After the myths about price and equivalency have been shattered, one fact stands out more clearly than ever: *The maker does matter.* As always, your best guide to drug therapy for your patients is to select products—both brands and generics—from manufacturers with credentials and performance records you have come to respect.

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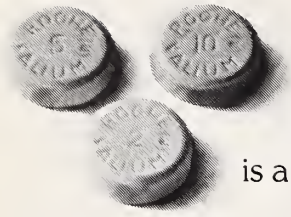
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Drinking and Pregnancy — A Hazardous Combination

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A character all its own.



Valium (diazepam/Roche) is a benzodiazepine with a character all its own. Pharmacologically, it is a potent skeletal muscle relaxant and anticonvulsant (in adjunctive use), as well as an antianxiety agent. Pharmacokinetically, only Valium provides active *diazepam* as well as the active metabolites 3-hydroxydiazepam, desmethyldiazepam and oxazepam.

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Another important aspect of the clinical character of Valium is safety. Though drowsiness, ataxia and fatigue are possible, these and more serious side effects are rarely a problem. Of course, as with all CNS-acting drugs, patients taking Valium should be cautioned against driving, operating dangerous machinery or the simultaneous ingestion of alcohol.

Unquestionably, many psychotherapeutic agents, including other benzodiazepines, have antianxiety effects. But one fact remains: you get a certain kind of patient response with Valium. It's a response you want. A response you know. A response you trust as part of your overall management of anxiety and psychic tension.

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diazepam/Roche

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Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology; spasticity caused by upper motor neuron disorders; athetosis; stiff-man syndrome; convulsive disorders (not for sole therapy).

The effectiveness of Valium (diazepam/Roche) in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

Usage in Pregnancy: **Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

Dosage: Individualize for maximum beneficial effect. *Adults:* Tension, anxiety and psychoneurotic states, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. *Geriatric or debilitated patients:* 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) *Children:* 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

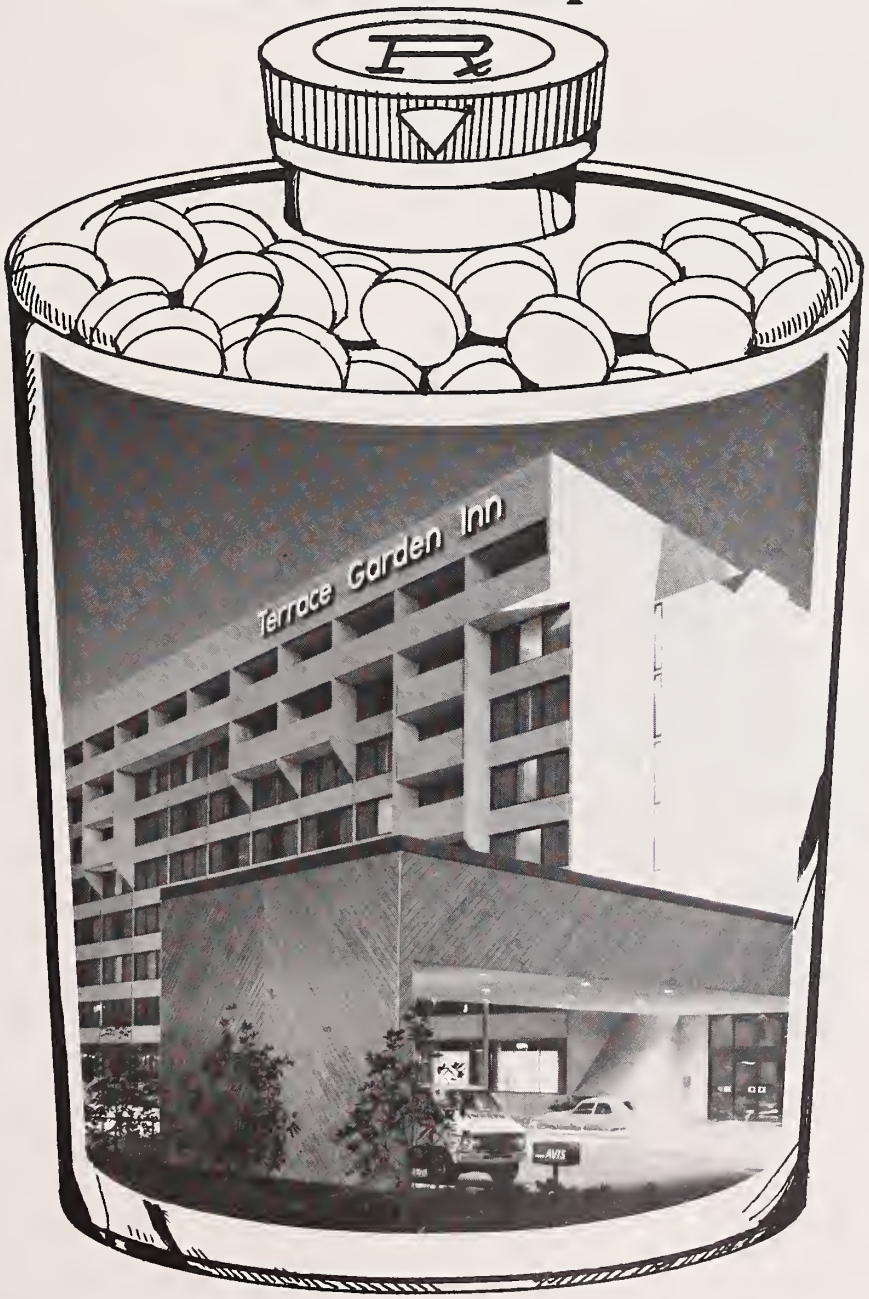
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Psychiatric Hospital

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THE COVER

Our cover, designed by Mindy Warren, depicts a primary objective of this month's issue, namely, to alert the practicing physician to advise his "at risk" patients of the harmful effects of ethanol on a developing fetus. An article by Ms. Iris Smith (p. 799) reviews the literature on the subject of fetal alcohol syndrome (FAS), and one by Dr. Barbara Williams (p. 805) presents case reports and a description of the pathogenesis of FAS.



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Letters to the Editor . . .

Sports Medicine — A Coach's Viewpoint

Dear Sir:

Fifteen years ago, at the Georgia Athletic Coaches Clinic in Atlanta, the last session on the clinic schedule was a 2-hour lecture and demonstration by two doctors from Atlanta, including Fred Allmon, M.D., on sports medicine. There were approximately 10 coaches in attendance. Dr. Allmon and his associates were highly enthusiastic and had obviously gone into considerable depth in preparation and research to pinpoint the major problem areas of sports medicine. As a result of their lectures and film demonstrations, my way of thinking about working with young athletes changed considerably.

Like most coaches who did their playing before 1964, the use of liquids to replace fluids lost during practice was considered a weakness and never done. This may be one of the most noteworthy changes for which we can thank our friends in the medical profession, because today we as coaches on all levels replace lost fluids on the spot at practice and during competition with large quantities of a saline solution. Dr. Allmon stressed the importance of this first and foremost.

The next demonstration by Dr. Allmon was color movies of shoulder, knee, and ankle surgery. I weakened at the sight, because each was that of a well-known athlete from the university nearby. Some were pro athletes, and the sequence of events leading to the injuries were stressed in the film.

Each time an injury was discussed, a method of prevention was also stressed. I discovered that improper coaching techniques and failure to properly condition our athletes, as well as faulty equipment or improperly wearing and using the equipment was responsible for the great majority of injuries. In other words, we coaches need to accept our responsibility for these fine young players who show up for us to coach. The pros draft their players, the colleges recruit theirs, but the high schools must build their players from the availability of those who want to participate.

I was proud to make the acquaintance of Dr. Fred Allmon, and his continued friendship has been beneficial to me through the years. I find that more and more coaches, like myself, are realizing the importance of seeking the advice of the medical profession in the area of sports medicine to improve our situation in the hundreds of school districts throughout the state of Georgia.

Each team needs the daily help of a medical doctor, with some special training in the area of sports medicine, because athletes have special problems and needs.

I have been twice blessed with doctors who cared about my teams. While coaching in Rome, Georgia, at West Rome High School, Dr. Richard Gray looked after our athletes with professional and fatherly concern. The parents in Rome developed a trust in Dr. Gray that few people enjoy in any profession. Since coming to Valdosta, I have had the enormous pleasure to work with Dr. Jose Campa. Dr. Campa starts a file in the seventh grade for each of our athletes, and this record follows him through high school along with his academic record. Dr. Campa closes his busy office (orthopedic practice) at 3 p.m. on each practice day in the fall and in the spring to attend practice session at both our junior high and senior high schools. He has only missed one game for our Wildcats during the past 7 years, and we've played quite a few (29 in the past 2 years). Dr. Campa works extremely well with the members of his profession at the South Georgia Medical Center and cooperates with the other doctors so that he can swap or otherwise arrange with them to be on duty on the nights we have games.

You must remember that I'm speaking on a high school level, and as a coach I have had to cultivate and make these fine doctors welcome in our program. All of our coaches listen to Dr. Campa on sports medicine matters, because he has studied and contributed so much to the progress of sports medicine.

In conclusion, I would like to say that the coaching and medical professions can and are having a great impact on all of us because we are a sports-oriented society. I would like to speak for myself and my fellow coaches throughout the state of Georgia in thanking the medical profession for helping to make competitive team sports better at all levels and pledge to you our continued cooperation. We all want a championship team, and a healthy, well-trained, highly-conditioned athlete is the secret to that success.

Sincerely,
Coach Nick Hyder
Valdosta

Re: Neonatal *H. Influenzae* Meningitis

Dear Sir:

I read with interest the article by Joiner and Henderson titled "Neonatal *Hemophilus Influenzae* Meningitis — A Case Report," which appeared in the June 1979 issue.

I feel that it is a fine report that serves to remind clinicians that neonatal *H. influenzae* infections do occur. However, I must take exception with the authors' conclusion that there has been an increase in neonatal *H. influenzae* meningitis in recent years. While I agree that *H. influenzae* should be considered in the differential diagnosis of neonatal Hemophilus gram-negative meningitis, I feel that the authors' data failed to substantiate their conclusion. In fact, early in the same paper the authors themselves say that the reported incidence of neonatal *H. influenzae* meningitis during the most recent 6-year period represented an incidence basically unchanged from the preceding 40-year period. I felt that this inconsistency within the above article deserved clarification.

Sincerely,
Carlos E. Lopez, M.D.
Atlanta


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MEDICAL MEETING CALENDAR

SEPTEMBER

18—*Atlanta;* **CURRENT ISSUES IN CHILD DEVELOPMENT AND PSYCHOPATHOLOGY;** (8 Session Course); Category 1 credit; Contact: Extension Committee, Atlanta Psychoanalytic Society; Ste. 913, 3400 Peachtree Rd., NE, Atlanta 30326. PH: 404/266-2887.

20-22—*Sea Island;* **ANNUAL MEETING, GEORGIA SURGICAL SOCIETY;** Category 1 credit; Contact: W. Cecil McGarity, M.D., 1365 Clifton Rd., NE, Atlanta 30322.

26—*Atlanta;* **INFANT NUTRITION: A FOUNDATION FOR LASTING HEALTH? PHASE II: MEDICAL UPDATE—CLINICAL ENCOUNTERS** (Closed-circuit televised live Symposium); Category 1 credit; Contact: The University of Iowa College of Medicine, c/o Health Learning Systems, Inc., P.O. Box 4243, New York, NY 10017. PH: 212/682-0705.

27-28—*Atlanta;* **CANCER SYMPOSIUM;** Category 1 credit; Contact: Mr. David Moss, Symposium Coordinator, Bristol Laboratories, P.O. Box 657, Syracuse, NY 13201 (Co-sponsored with University of Alabama Comprehensive Cancer Center).

27-29—*Atlanta;* **MEETING, AMERICAN DERMATOLOGIC SOCIETY FOR ALLERGY AND IMMUNOLOGY;** Contact: R. S. Rogers III, M.D., Department of Dermatology, Mayo Clinic, Rochester, MN 55901.

28-30—*Callaway Gardens;* **31ST ANNUAL MEETING, GEORGIA HEART ASSOCIATION;** Category 1 credit; Contact: Georgia Heart Association, 2581 Piedmont Rd., NE, Atlanta 30324.

OCTOBER

1-3—*Atlanta;* **AMERICAN COLLEGE OF EMERGENCY PHYSICIANS** (ACEP)—**SYMPOSIUM ON POISONING;** Category 1 credit; Contact: ACEP Convention Services. PH: 517/321-7911.

1-3—*Kiawah Island, SC;* **PRIMARY CARE OF HAND INJURIES;** Contact: American Society for Surgery of the Hand, 2600 South Parker Rd., Ste. 132, Aurora, CO 80014. PH: 303/755-4588.

1-4—*Atlanta;* **AMERICAN COLLEGE OF EMERGENCY MEDICINE SCIENTIFIC ASSEMBLY;** Contact: William H. Just, Director of Convention Services, American College of Emergency Physicians, 3900 Capital City Blvd., Lansing, MI 48906. PH: 517/321-7911.

2-3—*Atlanta;* **WORKSHOP ON PRACTICE MANAGEMENT: THE PHYSICIANS' WORKSHOP** (2 days); **THE MEDICAL ASSISTANTS' WORKSHOP** (1 day); Category 1 credit; Contact: American Academy of Orthopaedic Surgeons, 444 N. Michigan Ave., Chicago, IL 60611. PH: 800/421-6512.

2-4—*Augusta;* **BASIC EKG FOR FAMILY PHYSICIANS;** Category 1 credit; Contact: Dr. Gerald T. Chambers, Division of Continuing Education, Medical College of Georgia, Augusta 30912. PH: 404/828-3967.

4-5—*Atlanta;* **WORKSHOP ON PRACTICE PRODUCTIVITY: THE PHYSICIANS' WORKSHOP** (2 days); **THE MEDICAL ASSISTANTS' WORKSHOP** (1 day); Category 1 credit; Contact: American College of Obstetricians & Gynecologists, One E. Wacker Dr., Chicago, IL 60601. PH: 800/421-6512.

4-5—*Hilton Head Island, SC;* **FRONTIERS IN NUTRITION;** Category 1 credit; Contact: Georgia Institute of Human Nutrition, Room CB 3E14, Medical College of Georgia, Augusta 30912.

5—*Atlanta;* **ADVANCES IN COLON AND RECTAL CANCER—PROGRESS 1979;** Category 1 credit; Contact: The Department of Graduate and Continuing Medical Education, Georgia Baptist Medical Center, 300 Boulevard, NE, Atlanta 30312.

5-6—*Knoxville, TN;* **REGIONAL MEETING, AMERICAN COLLEGE OF PHYSICIANS AND TENNESSEE SOCIETY OF INTERNAL MEDICINE;** Category 1 credit; Contact: Blair D. Erb, FACP, Jackson Clinic, 616 W. Forest, Jackson, TN 38301.

8-9—*Johnson City, TN;* **GERIATRICS II: SEX AND THE AGED;** Contact: Dr. Charles F. Johnson, Department of Continuing Medical Education, East Tennessee State University College of Medicine, Johnson City, TN 37601. PH: 615/929-5364.

8-11—*Atlanta;* **ANNUAL MEETING, AMERICAN ACADEMY OF FAMILY PHYSICIANS;** Contact: R. Tusken, Executive Director, 1740 W. 92nd St., Kansas City, MO 64114.

11—*Atlanta;* **HYPERTENSION IN FAMILY PRACTICE: PRESENT AND FUTURE;** Category 1 credit; Contact: World Health Information Services, Inc., 505 Park Ave., New York, NY 10022. PH: 212/751-5737.

11-13—*Charleston, SC;* **ANNUAL MEETING, SOUTHEASTERN ALLERGY ASSOCIATION;** Contact: G. Frederick Hieber, M.D., Secretary-Treasurer, Southeastern Allergy Association, 1401 Monticello Blvd., N., St. Petersburg, FL 33703. PH: 813/525-0861.

18-19—*Knoxville, TN;* **CANCER CONCEPTS 1979;** Contact: Dennis K. Wentz, M.D., UT Center for the Health Sciences, 62 S. Dunlap St., Memphis, TN 38163. PH: 901/528-5606.

19-21—*Atlanta;* **PSYCHOANALYSIS AND PSYCHOTHERAPY: SIMILARITIES AND DIFFERENCES;** Sponsored by the Southern Psychoanalytic Society and the Atlanta Psychoanalytic Society. Category 1 credit; Contact: Ralph Roughton, M.D., Registrar, P.O. Box 122, Colony Square, Atlanta 30361. PH: 404/892-7561.

24-26—*Birmingham, AL;* **INFECTIOUS DISEASES;** Category 1 credit; Registrar, American College of Physicians, 4200 Pine St., Philadelphia, PA 19104.

24-29—*Atlanta;* **MEETING, AMERICAN ACADEMY OF CHILD PSYCHIATRY;** Contact: V. Q. Bausch, Executive Director, American Academy of Child Psychiatry, 1424 16th St., NW, Washington, DC 20036.

25-26—*Atlanta;* **ORGANIZED PAIN: THE MANAGEMENT OF A PAIN CONTROL CENTER;** Contact: Mr. Ronald G. Havican, Center for Rehabilitation Medicine, 1441 Clifton Rd., NE, Atlanta 30322.

27-28—*Callaway Gardens;* **PHYSICIAN PLACEMENT SEMINAR;** Contact: Joyce Butler, Medical Association of Georgia, 938 Peachtree St., NE, Atlanta 30309. PH: 404/876-7535.

27-28—*Nashville, TN;* **AMA REGIONAL CME MEETING: CARDIAC ARRHYTHMIAS; PULMONARY FUNCTION & BLOOD GASES: ACID-BASE, FLUID, & ELECTROLYTE BALANCE; BASIC CPR; INFECTIOUS DISEASES; OFFICE ORTHOPEDICS; ADVANCED CPR;** Category 1 credit; Contact: Council on Continuing Physician Education, AMA—535 N. Dearborn St., Chicago, IL 60610. PH: 312/751-6000.

For additional information on these and other meetings, contact MAG, Division of Education 404/876-7535.

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Brief Summary

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Product Information as of September, 1977

U.S. Patent 2,985,558

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*__Indications:__ Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, the FDA has classified the indications as follows:

Possibly Effective:

1. For the relief of symptoms associated with cerebral vascular insufficiency.
2. In peripheral vascular disease of arteriosclerosis obliterans, thromboangiitis obliterans (Buerger's Disease) and Raynaud's disease.

Final classification of the less-than-effective indications requires further investigation.

Composition: Vasodilan tablets, isoxsuprine HCl, 10 mg. and 20 mg.

Vasodilan injection, isoxsuprine HCl, 5 mg., per ml.

Dosage and Administration: Oral: 10 to 20 mg., three or four times daily.

Intramuscular: 5 to 10 mg. (1 or 2 ml.) two or three times daily. Intramuscular administration may be used initially in severe or acute conditions.

Contraindications and Cautions: There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding.

Parenteral administration is not recommended in the presence of hypotension or tachycardia.

Intravenous administration should not be given because of increased likelihood of side effects.

Adverse Reactions: On rare occasions oral administration of the drug has been associated in time with the occurrence of hypotension, tachycardia, nausea, vomiting, dizziness, abdominal distress, and severe rash. If rash appears the drug should be discontinued.

Although available evidence suggests a temporal association of these reactions with isoxsuprine, a causal relationship can be neither confirmed nor refuted.

Administration of single dose of 10 mg. intramuscularly may result in hypotension and tachycardia. These symptoms are more pronounced in higher doses. For these reasons single intramuscular doses exceeding 10 mg. are not recommended. Repeated administration of 5 to 10 mg. intramuscularly at suitable intervals may be employed.

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Fetal Alcohol Syndrome: A Review

IRIS E. SMITH, *Atlanta**

Introduction

In 1899, William Sullivan, a physician at a Liverpool prison, published the first scientific study of the effects of maternal drinking. The study sample consisted of 120 female prisoners and their offspring. In the offspring of women who drank during pregnancy, he found higher rates of stillbirths and mortality prior to the age of 2, with convulsions being the most frequent cause of death.[29]

A 1968 French study by Lemoine et al.[15] reported on 127 offspring from 69 alcoholic families. Twenty-five of the children, the offspring of maternal alcoholics presented a distinct pattern of malformations which included a protruding forehead, sunken nasal bridge, short upturned nose, thin upper lip, and ear and eye malformations. These findings were corroborated by Jones et al.[9] in 1973.

The first American study dealing with maternal alcohol intake and its effect on human fetal development was a retrospective study in 1970 by Ulleland.[28] Through a review of medical records from Jan. 1, 1968, to June 30, 1969, she was able to identify 11 women who were reported as being alcoholic. The infants of these women were then evaluated. Ten of these 12 children were found to be small for their gestational age. When evaluated for intellectual development with Gessell and/or Denver Developmental Scales, five of these 10 children exhibited retarded development. Six of the 12 children had failed to grow at a normal rate (below the third percentile in both weight and head circumference), in spite of the fact that they had received adequate diets. Two others assessed as being poorly fed at home failed to grow normally even when hospitalized. These eight children were subsequently examined, and a pattern of abnormalities was noted in four. Further retrospective analysis of the offspring of maternal alcoholics by Jones et al.[11] and later by Hanson[8] increased the number of children identified as exhibiting these abnormalities to 41. This observed pattern of abnormalities in children of maternal alcoholics has become known as the Fetal Alcohol Syndrome (FAS). The findings from these initial studies have subsequently been corroborated by similar observations in the offspring of alcoholic women reported from all parts of the world.

Characteristics of Fetal Alcohol Syndrome

In infancy, FAS is characterized by intrauterine and postnatal growth deficiency which is usually more evident in weight than height. Microcephaly, generally of prenatal onset, occurs in more than 80% of the identified cases. Many of these children, even when hospitalized for failure to thrive, continue to develop at a slower than normal rate.[26] Case studies of children identified with FAS indicate that this growth deficit may persist into adolescence. Clarren et al.[4] report decreased adipose tissue as a nearly constant feature of persons with FAS. This finding probably reflects the prenatal insult to cell proliferation leading to diminished fetal cell numbers and eventual limitation of size.

Children with FAS typically exhibit a "drawn" facial appearance resulting from several minor defects in cranio-facial development. Frequently the facial appearance is further altered by midfacial and mandibular growth deficiency.

The most consistently reported clinical feature of FAS has been short palpebral fissures which are believed to be secondary to ocular growth. Clarren et al.[4] reported this feature in more than 80% of their identified cases. A new normative study on palpebral fissure size in white newborns has recently been completed by Jones,[10] which updated and clarified

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TABLE 1: Principal Features of FAS*
(Observed in 245 Patients)

Area	*Feature*	*% of Cases*
Face	Short palpebral fissures (1.8 cm in infants 36 weeks of gestational age)	≥80
	Short upturned nose with flattened nasal bridge	≥50
	Hypoplastic philtrum	≥80
	Thinned upper vermilion	≥80
	Retrognathia in infancy	≥80
	Micrognathia or relative prognathia in adolescence	≥50
	Hypoplastic maxilla	≥50
Central nervous system	Mild-moderate retardation	≥80
	Microcephaly	≥80
	Irritability, tremulousness in infancy	≥80
	Poor coordination, hypotonia	≥50
	Hyperactivity in childhood	≥50
Growth	Pre- and postnatal less than 2 standard deviations below the mean for length and weight	≥80
	Disproportionally reduced adipose tissue	≥50

*Source: Clarren et al.[4]

some of the findings in the earlier studies. It should be noted, however, that the possibility of ethnic and racial variances in fissure size has not been dealt with to date. Other developmental abnormalities frequently observed in FAS children include cardiovascular defects[27] and renal abnormalities.[5, 6, 8, 15] In addition, there is an occasional report of hirsutism, hypoplastic nails, irregularities of genitalia, poorly formed ears, ptosis, strabismus, hemangiomas, and musculo-skeletal abnormalities (most notably limited joint movement and hip dislocation), aberrant palmar creases, and diaphragmatic abnormalities in this population. Table 1 summarizes the principal features of FAS.

Mental deficit is one of the most consistently reported manifestations of FAS found in the literature. One problem in evaluating the degree of mental deficit attributable to FAS has been the failure of many researchers to use standardized measurement techniques in the evaluation of FAS children. However, of the 126 patients with the morphologic characteristics of FAS described in the literature as having been evaluated with standardized testing procedures, 107 scored at least two standard deviations below the mean for their age group.

Neuropathologic studies[3, 4] of FAS infants who died at an early age demonstrated structural malformations in their brains. The most consistent basis for these malformations was reported as failure or interruption in neuronal and glial migration patterns. One of the most intriguing findings is that of the four infants examined in one study, who exhibited structural brain malformations, only two had been diagnosed clinically as having the syndrome.[3] This indicates that actual tissue damage based on clinical evaluations may be underestimated.

Clinical observations of children with FAS indicate a possible association between the syndrome and the incidence of hyperactivity.[4, 15, 25, 27] In a recent study of 11 offspring of alcoholic mothers who exhibited partial features of FAS but tested within the normal range of intelligence, Shaywitz[25] found a high incidence of minimal brain dysfunction as evidenced by learning disorders and deficits in attention and memory. Similar findings were reported by Lemoine et al.[15]

Evidence from the animal studies of FAS clearly suggest that ethanol ingestion by the mother during pregnancy is the primary teratogenic factor. The types of malformations observed in the animal studies correspond to those observed in the offspring of alcoholic women.[1, 2, 19, 22]

Prospective Studies

There are three major prospective studies reported to be underway in the United States:

At the University of Washington School of Medicine, a longitudinal study is being conducted involving 1,529 pregnant women and their offspring. The focus of this study is on both biologic and behavioral outcomes of pregnancy as related to maternal alcohol consumption. The study sample is primarily composed of white, middle class, fairly well-educated women. All were receiving prenatal care at two large Seattle hospitals by their 5th month of pregnancy. Several sub-studies have been conducted on this initial sample of women and their offspring.

A preliminary sub-sample of 163 offspring from this group of women was selected in order to study the effects of moderate alcohol consumption on fetal development.[7] The mothers were divided into three groups: Group A were women who reported an average consumption greater than or equal to 1 oz. of absolute alcohol per day; Group B was composed of women who consumed less than 1 oz. of absolute

alcohol per day; Group C were identified as controls. (One problem with this last group, however, was that it included women who reported drinking between 0.11 and 0.9 oz. of absolute alcohol per day). A significant relationship was found between the amount of alcohol consumed in the month prior to recognition of pregnancy (probably including the first weeks after conception) and the extent of fetal dysmorphogenesis.

"Mental deficit is one of the most consistently reported manifestations of FAS. . . ."

The infants were evaluated on the basis of (a) size (above or below the 3rd percentile in length and/or weight); (b) microcephaly; (c) short palpebral fissures, (d) presence of multiple dysmorphic features suggestive of FAS (low nasal bridge, epicanthal folds, hemangiomas, altered palmar creases, cardiac murmurs, and ear anomalies). The infants were then separated into three categories: (1) those with features compatible with FAS (exhibiting two or more of the aforementioned criteria, plus short palpebral fissures or multiple dysmorphic features); (2) those with minor abnormalities not indicative of FAS; and (3) those who were assessed as essentially normal or who exhibited normal variants and single borderline abnormalities.

Of 16 women who reported drinking more than 2 oz. of absolute alcohol per day in the month preceding recognition of pregnancy, three (19%) delivered infants having features suggestive of FAS. Of 54 women who consumed between 1 and 2 oz. absolute alcohol per day in the month prior to recognition of pregnancy, six (11%) delivered infants with features compatible with FAS. Two women who reported drinking 1 oz. or less of absolute alcohol also delivered infants with features compatible with FAS.

Two other sub-studies examined the effects of maternal alcohol and nicotine intake on neonatal behavior profiles. The data from these studies indicated that even relatively small amounts of alcohol when consumed by the mother just prior to and/or during the first 5 months of pregnancy significantly influenced the ongoing behavior of the newborns. The first of these studies, which examined the effects of alcohol and nicotine on newborn conditioning, found that infants of mothers who consumed alcohol and nicotine during or prior to pregnancy exhibited a decreased ability to perform two different learning tasks when compared to the control group.[18] The second study which utilized observations of naturally occurring behavior found a higher frequency of tremors, increased hand-to-mouth activity and increased yawning/sneezing in offspring of women who drank during pregnancy.[14] These behavior changes are similar to those observed in infants undergoing narcotic withdrawal.

Additionally, it was noted that the combination of heavy social drinking and heavy nicotine use during pregnancy produced the most detrimental effects on the infants. These effects were greater than the predicted effects for either alcohol or nicotine alone. The question of whether these behavior changes are predictive of future deficits in development is currently being addressed in the follow-up studies of the original cohort of 500 infants.

A second study is being conducted at Boston City Hospital (BCH) in Massachusetts.[21, 24] The initial study sample (which reflected the ethnic composition of the population served by BCH) was 54% black, 27% white, 13% Hispanic, and 6% American Indian. A total of 633 women were selected for this study. The women were surveyed through the use of a questionnaire and then divided into three groups according to their score on Cahalan's Volume Variability Index.[1] They were then followed throughout their pregnancies, and their infants were evaluated by a pediatric neurologist. Twenty-nine of the 42 infants (69%) born to heavy drinkers were found to be "abnormal" based on their size, the presence of congenital malformations, or neurologic deficits. This was contrasted with 35% and 34% incidence, respectively, of "abnormal" infants in the moderate and abstinent groups.

The results of this study raise a number of questions. What is most apparent is that this study sample appears to be part of a unique population. In the Boston study, Ouelette et al.[21] report an incidence of 9% and 14% for congenital abnormalities in the abstinent and moderate drinking women, respectively. This is high when compared to the incidence of congenital malformations reported in four other areas of the United States which range from 2-4%.[30] Unfortunately, the malformations which were observed in this study were not described.

"What is most apparent is the need for further prospective follow-up of children identified with FAS. . . ."

In a high risk population such as this one, where 35% of all infants born are reported to be "abnormal" to the extent that they must be referred to intensive care, it is not surprising that some of the more subtle manifestations of FAS found in children of alcoholic mothers were not reported. It should be noted that when compared to the other two groups, the infants produced by the group of heavy drinking women in this study were found to exhibit significant differences in several areas: growth ($p \leq .001$); the incidence of microcephaly ($p \leq .001$); presence of

neurologic deficit as evidenced by jitteriness ($p \leq .001$) and/or poor sucking reflex ($p \leq .05$); and the presence of multiple congenital abnormalities ($p \leq .001$).

The third and perhaps largest prospective study undertaken to date is being done at Loma Linda University Medical Center in California, and involves a sample of 6,000 pregnant women. Data from this study are not yet available.

Problems with Current Research Strategies

The majority of FAS cases reported in the literature are offspring of chronically alcoholic women, many of whom have been treated for complications secondary to their alcoholism. A major criticism has been that these cases represent only the most extreme end of a continuum.[23] American drinking patterns reflect an almost indeterminable number of variations. This raises the question of variability in the teratogenic effects of alcohol during pregnancy.

As a group, the mothers described in the retrospective studies and individual case reports are generally in the age range of late 20's to early 30's and are multiparous. In the Hanson et al.[8] series of 41 patients, all of the mothers were reported as chronic alcoholics with secondary complications including cirrhosis, pancreatitis, and gastritis. Three of the women in this series are reported to have died as the result of health complications secondary to alcoholism. In a series of seven patients with FAS, Mulvihill[20] reported the mothers as ranging in age from 25 to 32 years, with a mean age of 30.3 years. All were multiparous, with a range of 4-9 deliveries. In a series of 16 cases, Loser[16] reported a range of 2-14 years duration of heavy alcohol use in a German population of women investigated with regard to FAS. Individual case reports reflect similar findings.

The evidence from the retrospective studies and the individual case reports clearly indicates a relationship between ethanol intake by the mother and altered fetal development. However, one weakness inherent in any retrospective study is the lack of control over possible contributing and interacting variables other than the variable being tested. Although each of the mothers in these studies was identified as a chronic alcoholic or "heavy drinker," the pattern of drinking during pregnancy is frequently not reported, and in some cases specific detail of the pregnancy itself (such as nutritional status of the mother, major/minor infections, other drug exposure etc.) is unknown.[4]

There are also several problems inherent in the prospective studies. The most significant of these is the problem of assessing the accuracy of the data. Any study which attempts to utilize self-report data must give consideration to this problem. This is especially true where the subject matter is as potentially sensitive as alcohol consumption during pregnancy. Furthermore, most of the women included in the prospective studies are interviewed at the time they register for prenatal care. Since many are already into their second trimester of pregnancy, this requires retrospective reports of daily drinking patterns over a 3-5 month period, which introduces questions with regard to the accuracy of the information.

It is difficult to draw conclusions from the data which has been reported from the two major prospective studies as to the threshold of toxicity for alcohol consumed. One reason for this is that there is no uniformity in the methods used to assess consumption levels. The categories "heavy," "moderate," "rare," and "infrequent" are used almost interchangeably, and in some cases they actually overlap. In the Boston study, for example, "heavy" drinkers were described as women who consistently averaged between 174 ml (5.8 oz.) and 45 ml (1½ oz.) of absolute alcohol per day and who drank five or more drinks per occasion. In Hanson's study of the effects of moderate drinking, "moderate" was defined as 1 oz. or more of absolute alcohol per day or reports of intoxications during pregnancy, with ingestions of five or more drinks per occasion.[7] Three of the women in this study reported drinking "substantially more" than 2 oz. of absolute alcohol per day.

Although difficult to assess, the relative significance of long-term, continuous exposure to alcohol versus sporadic, high-volume consumption has not been dealt with in these studies. Furthermore, the effect of paternal alcohol consumption on fetal outcome has not been investigated.

"The evidence from the retrospective studies and the individual case reports clearly indicates a relationship between ethanol intake by the mother and altered fetal development in her offspring."

There are many questions which remain unanswered by the research studies. What is most apparent is the need for further prospective follow-up of children identified with FAS, particularly those with partial FAS expression, to determine if there are in fact long-term functional abnormalities in these children. Recent studies of neonatal behavior profiles suggests that even moderate amounts of alcohol during pregnancy (i.e. average of 1-1½ drinks per day, with occasional ingestion of 2-5 drinks) can cause changes in neonatal behaviors which are suggestive of alcohol and narcotic withdrawal.[14, 24]

Whether or not these behavior changes in the newborns are predictive of permanent neurologic damage or future deficits in development will only be revealed by further follow-up in well-designed, prospective studies.

Most of the women who produced FAS infants reported a history of heavy alcohol consumption several years prior to pregnancy. What is the significance of alcohol consumption prior to conception? In Hanson's Seattle study of moderate drinking, consumption during the month preceding pregnancy recognition was found to be significant for the production of infants with features of FAS. The question of whether the risk of producing FAS infants increases with the duration of alcohol use preceding pregnancy remains unanswered. Furthermore, the association between increased tolerance levels in chronic alcoholic women and the frequency of the FAS has not been examined. The majority of the women who have produced FAS infants, although alcoholic, have reported giving birth to normal infants in previous pregnancies. What is the incidence of FAS within a population of alcoholic women? This is still an unanswered question. Are there other factors interacting with the effects of ethanol consumption?

The use of pair-fed controls in the animal studies appears to have eliminated nutrition as a significant contributing factor, although the possibility of an interactive effect cannot be discounted.

A Proposed Research Study

In persons identified as alcoholics, there is evidence of cytogenetic and possible biochemical alterations. At the present time, it is not known whether these alterations contribute to the development of FAS in the offspring of alcoholics.

A research program is being developed by Georgia's FAS Task Force* which is aimed at identifying women who drink more than two drinks per day (1 oz. absolute alcohol) during pregnancy and evaluating their high risk offspring. Detailed pediatric and neurologic evaluations will be performed both at birth and during the recovery period. Behavioral characteristics such as state, organization, sensitivity to sensory stimulation, and motor organization will also be evaluated at this time. Laboratory analysis of blood samples from both infants and mothers will assess possible genetic damage both at the chromosome and DNA levels. By analyzing the data obtained from these investigations, we hope to arrive at a more precise understanding of the impact of alcohol on the developing fetus and provide a more definitive basis for diagnosing FAS.

"A research program is being developed by Georgia's FAS Task Force to identify women who drink more than 1 oz. per day during pregnancy and to evaluate their offspring."

Summary — What We Know Now

A total of 245 cases of FAS have been identified in the retrospective and prospective studies.[4] The frequency of the full syndrome has been estimated at between one and two per 1,000 live births. The frequency of partial expression is estimated at between three and five per 1,000 live births. Based on the currently available data, we do know that ethanol or some metabolic by-product thereof is the primary teratogenic agent. What is known is that the peculiar pattern of abnormalities associated with FAS has been observed in the offspring of women who regularly consumed alcohol during pregnancy. Women who consume an average of 1-1½ drinks of alcohol daily are at risk for the production of infants small for gestational age, stillbirths, and infants who exhibit behavior suggestive of alcohol withdrawal.[12, 14, 24] Women who consume an average of 5-6 drinks of alcohol daily during pregnancy or in the month preceding pregnancy recognition seem to be at an increased risk for the production of FAS infants.

In regard to prevention, these data clearly indicate that women who are in the early stages of pregnancy or who are thinking of becoming pregnant should be advised to abstain from the consumption of alcoholic beverages. In most instances, by the time a woman realizes she is pregnant, a great deal of fetal brain growth has already occurred. If a women is identified as an alcoholic, she should be referred to an appropriate agency where she can obtain help in overcoming her drinking problem.

For diagnostic purposes in the newborn, the full FAS encompasses three distinct areas of manifestation: (1) pre- and postnatal growth retardation; (2) the presence of neurologic deficit as evidenced by jitteriness, tone, sucking response etc.; (3) abnormal facies resulting from several minor defects in cranio-facial development, including shortened palpebral fissures (less than 1.8 cm in infants 36 weeks gestational age),[7] diminished or absent philtrum, flattened nasal bridge, ear anomalies, and/or mid facial hypoplasia. Once a child has been identified with FAS, the physician should be prepared to offer medical support to the mother and family of the child. When indicated, referrals should be made to appropriate social service and health agencies for additional follow-up studies.

* The Fetal Alcohol Syndrome Task Force was organized by the Georgia Dept. of Human Resources in January, 1979 in order to develop statewide strategies to increase public awareness of the Fetal Alcohol Syndrome.

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Three Fetal Alcohol Syndrome case reports are presented, as well as results from animal studies with a description of the pathogenesis.

The Effect of Maternal Alcohol Consumption During Pregnancy

BARBARA WILLIAMS, M.D., *Atlanta**

Historical Background

THE DELETERIOUS effects of maternal alcohol consumption on the fetus have long been recognized. The early Carthaginians recognized this and thus forbade alcohol to newlyweds to prevent conception of malformed children. In 1621, in *The Anatomy of Melancholy,* Burton quotes Aristotle: "Foolish and drunken and harebrained women most often bring forth children like unto themselves, morose and languid." The Gin Epidemic in England in the first half of the 18th Century caused the College of Physicians to appeal to Parliament for tighter controls on alcohol, stating that parental drunkenness was "a cause of weak, feeble, and distempered children." Sullivan, at the turn of the century, studied 120 female alcoholic inmates in the Liverpool jail and found a perinatal mortality rate 2.5 times greater than that of their non-drinking female relatives.[1]

In America, after the repeal of Prohibition, there was a general rejection and ridicule of these earlier observations. In 1955, the Yale Center for Alcohol Studies released a pamphlet stressing that "the old notions about children of drunken parents being born defective can be cast aside."[2] The 1975 edition of Goodman and Gilman's Pharmacology text has the statement that "alcohol gains free access to the fetal circulation but it does not seem to harm the fetus."[3]

In 1967, Fuchs demonstrated the effect of alcohol on inhibiting uterine contractions in threatened premature labor.[4] The subsequent widespread use of such therapeutic infusion of ethanol, which is known to be readily transferred to the fetus by the placenta,[5] stimulated research on the effects of ethanol on the fetus.[6-10]

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Morphologic Characteristics of Fetal Alcohol Syndrome

In 1973, Jones and Smith described for the first time in the United States a recognized pattern of multiple congenital anomalies with microcephaly, short palpebral fissures, cardiac anomalies, and prenatal onset of retardation of growth and development.[11] Similar morphologic characteristics had been observed by Lemoine in France among 25 children of chronic alcoholics.[12] Figures 1[11] and 2[11, 13] show the characteristic hand and facial malformations associated with the Fetal Alcohol Syndrome (FAS). The principal features of FAS are listed in Table 1 with the frequency of observation found among the 41 children studied by Hanson, Smith, and Jones[13] compared with three children determined to have FAS at Grady Memorial Hospital in November 1977. These latter three children will be presented in this paper as a confirmation of earlier descriptions of FAS and in order to more fully delineate some deviation from the now recognized syndrome.

Case Reports

Case #1: Baby T., a 1550-gram female, with a gestational age of 34 weeks, was born to a 31-year-old woman. The mother had a history of chronic alcoholism of 8 years duration. She had been hospitalized or seen in the medical emergency clinic on various occasions, both prior to and during early pregnancy, for alcoholic hepatitis and alcoholic gastritis. She admitted drinking at least 1 pint per day of moonshine or package store liquor in the first 13 weeks of pregnancy.

Prenatal growth deficiency was demonstrated in her infant, with a birth weight and birth length at the

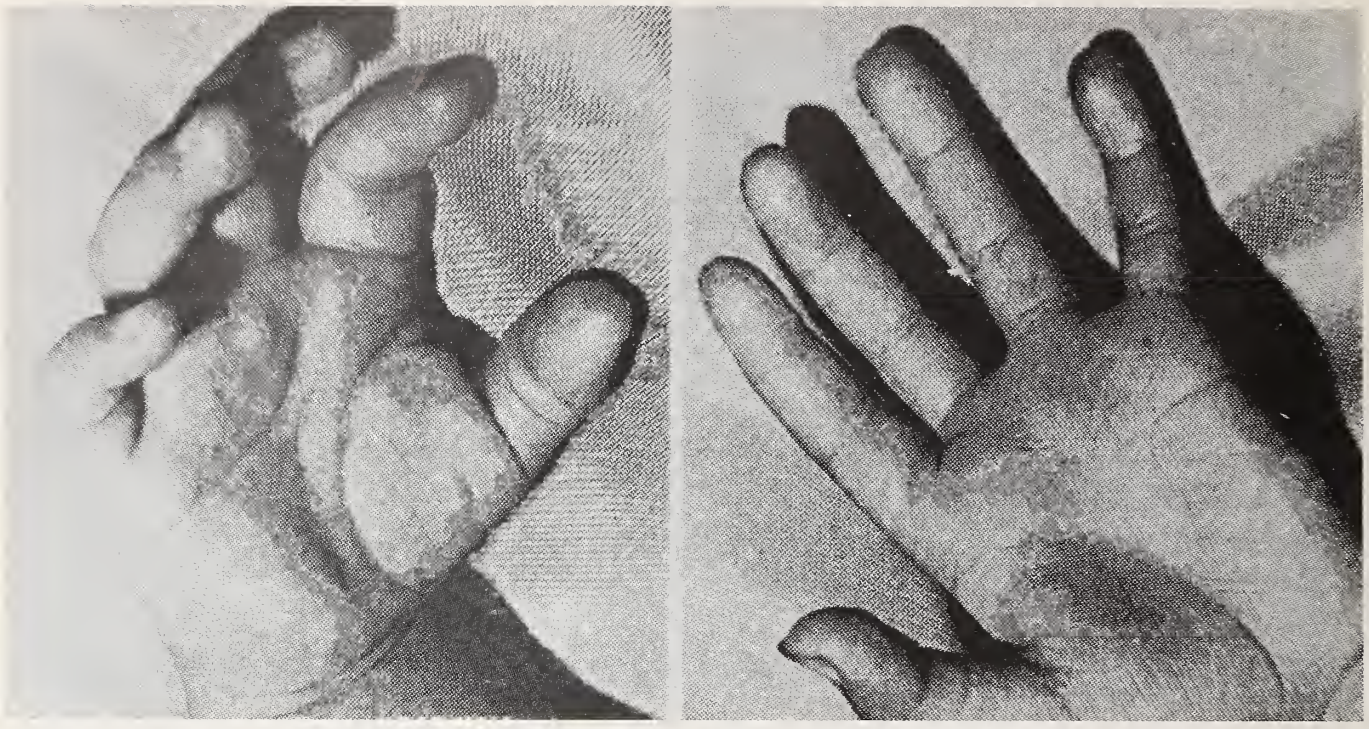


Figure 1 — Aberrant palmar crease patterns are characteristic of FAS.[11]

50th percentile for 29½ and 30 weeks gestation, respectively. Head circumference, however, was normal for 34 weeks. Microphthalmia, micrognathia, abnormal palmar creases, jitteriness, and hypoplastic labia majora were among the more common findings of the syndrome found in this newborn. In addition, hypoplastic ribs with a flail chest and hydronephrosis and hydroureter of the right kidney were also present. Renal anomalies have only recently been described in this syndrome, although the earlier case descriptions did not mention whether or not renal studies were done on the patients.[4] This infant was also found to have bilateral cataracts.

Case #2: Baby W., an 1100-gram male with a gestational age of 32 weeks, was born to a 39-year-old multiparous woman with a history of two miscarriages, and six previous premature births. In the past 8 years, the mother had presented to the medical emergency clinic on frequent occasions with trauma secondary to ethanol intoxication and alcoholic gastritis. Several of these occasions occurred during early pregnancy with this infant. Birth weight and birth length were both markedly deficient, at the 50th percentile for 27 weeks and 26 weeks gestation, respectively. Head circumference was 50th percentile for 28 weeks gestation. Common FAS dysmorphogenesis noted in this baby included microcephaly, microphthalmia, micrognathia, classic palmar creases, clinodactyly, hemangiomata, and jitteriness. Additionally, a ventricular septal defect was diagnosed, the most common cardiac defect found in children with FAS. This baby also had a cleft palate and eventration of the diaphragm.

Case #3: R.B., a 2½-year-old boy, was admitted to the hospital for a seizure disorder, and was found to have unusual facies consisting of microcephaly, microphthalmia, esotropia and ptosis of the right eye, severe myopia and retinal degeneration, elongated philtrum, classic palmar creases bisecting his first and second fingers, incomplete extension of both elbows, and low-set ears. He had prenatal and postnatal growth deficiency in birth length and weight, and subsequent height and weight measurements well below the 3rd percentile, marked retardation of both motor and intellectual function. At birth, he had been noted to be jittery, and had a right diaphragmatic eversion. Catheterization revealed valvular pulmonic stenosis, a cardiac defect noted in only one other published case of FAS.[15] Investigation revealed that his mother was a chronic alcoholic with multiple hospital admissions. She had died of cardiorespiratory arrest during an alcoholic withdrawal seizure when the child was 2 years of age, 8 months after he had been removed from her custody and placed in a foster home.

The average alcohol consumption may not be as important as the maximum blood alcohol concentrations obtained during binge drinking . . . in the first trimester.

A high blood alcohol level during a critical time of embryonic development probably is necessary to produce the full symptomatology of FAS. The average alcohol consumption may not be as important as

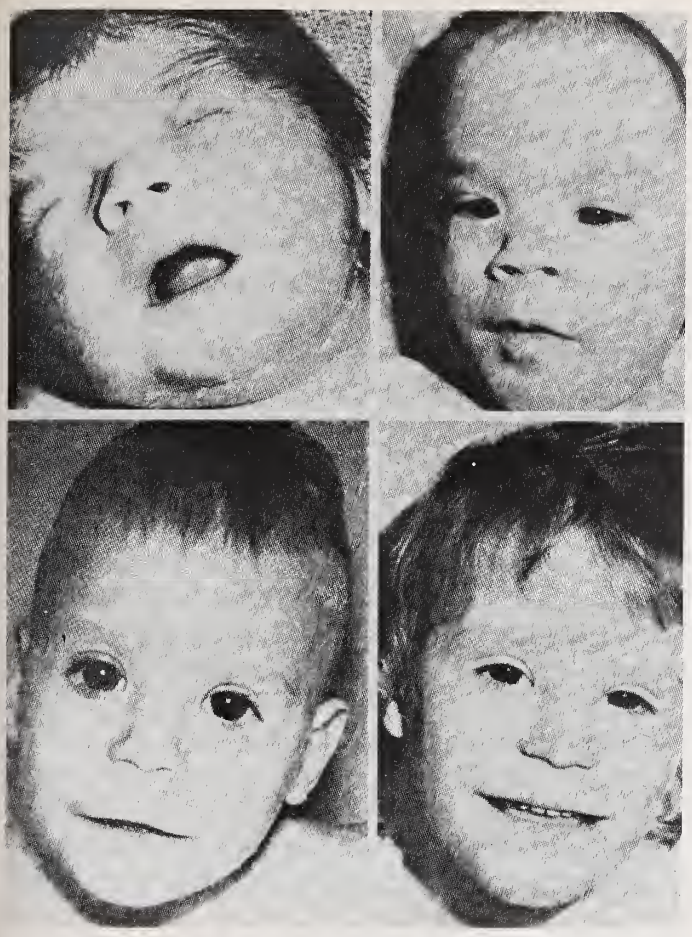


Figure 2 — Top: Boy with FAS at birth (L)[11] and at 6 months of age (R). Bottom: Girl with FAS at 16 months of age (L) and at 4 years (R).[13] Note short palpebral fissures, low nasal bridge with short or upturned nose, epicanthic folds, mid-face hypoplasia, and long convex upper lip with narrow vermilion border. A narrow bifrontal diameter, ocular ptosis, strabismus, wide mouth, prominent ears, and decreased periocular zone of hair inhibition are also common features.

the maximum blood alcohol concentrations obtained during binge drinking at critical periods in the first trimester. During the third trimester, it is more likely a chronic blood alcohol level that leads to pre- and postnatal growth deficiency and perhaps to some aspects of mental retardation. Animal models are necessary in order to control the multiple variables such as nutritional intake, caffeine, and nicotine consumption which so frequently accompany excessive alcohol intake in humans.

Results of Animal Studies

Despite the inevitable limitations of generalizing findings from animal studies to humans, the ability to control multiple variables which produce a compound obstetric risk make animal studies necessary and invaluable in studying the effect of varied amounts of alcohol on the fetus. To date, there is an animal model of the fetal alcohol syndrome in the chicken, mouse, rat, guinea pig, and zebra fish. Comparisons between humans and other animal species can best be made on the basis of blood alcohol concentrations, which is most critical in the mediation of the adverse consequences, and controls for differences in pathways and rates of alcohol metabolism among species.

St. Sandor[16] studied the effects of ethanol first in chick embryos, and later in albino rat fetuses. Early maldevelopment and mortality occurred in a considerable portion of the embryos, and the remaining subjects showed considerable and significant loss of

TABLE 1 — Common Abnormalities in Fetal Alcohol Syndrome

Abnormality	Number Affected	Number Observed	(%)[11]	Grady Memorial Hospital Case Reports #1	#2	#3
Growth and Performance						
Prenatal Growth Deficiency	38	39	(97)	+	+	+
Postnatal Growth Deficiency	37	38	(97)	+	+	+
Developmental Delay; Mental Deficits	31	35	(89)	?	?	+
Fine Motor Dysfunction	28	35	(80)	+	+	+
Craniofacial						
Microcephaly	38	41	(93)	−	+	+
Short Palpebral Fissures	35	38	(92)	+	+	+
Midfacial Hypoplasia	26	40	(65)	+	+	−
Epicanthic Folds	20	41	(49)	+	+	+
Limb						
Abnormal Palmar Creases	20	41	(49)	+	+	+
Joint Anomalies (minor)	17	41	(41)	+	+	+
Other						
Cardiac Defect	20	41	(49)	−	+	+
External Genital Anomalies	13	41	(32)	+	−	−
Hemangiomata	12	41	(29)	−	+	−

+ = present.
− = absent.
? = undeterminable.

weight toward the end of incubation. The central nervous system seemed to be the most sensitive organ. In the albino rats, St. Sandor found that 2 g/kg intravenous alcohol induced twice the number of abnormalities as 1.5 g/kg and that two heavy intoxications were more injurious than three lighter ones. Effects on the bones were most apparent in the extremities and facial areas, the same regions as observed in human infants with FAS.

The most dramatic effect of maternal alcohol consumption on the fetus is seen in the central nervous system.

Chernoff[17] administered alcohol orally to two strains of mice differing in ethanol preference and alcohol dehydrogenase activity. Blood alcohol levels of 73% to 398% were achieved, equivalent to 3 ounces of absolute alcohol for 73 mg% blood alcohol concentration in man. Chernoff found a definite growth deficiency due to ethanol, with fetal abnormalities involving skeleton, brain, heart, and eyes, similar to that of FAS in humans. The rat strain with the lower alcohol dehydrogenase activity was more sensitive to the effects of alcohol, which is significant in the light of recent studies which show ADH to be an isoenzyme, with human fetuses having only one of these isoenzymes present in the liver prior to 20 weeks gestation, with an enzyme activity level only 3-4% that of the adult liver.

Kronick[8] in 1976 administered varying levels of ethanol to pregnant mice and established a dose response curve, with fetal death occurring in response to the highest maternal doses, and varying degrees of growth deficiency and malformations occurring with lower doses. The animal studies are quite compelling and clearly suggest a risk for fetal outcome in humans when alcohol consumption is 3 to 4 ounces or more of absolute alcohol per day, i.e. six to eight drinks. It is to be emphasized that it is not necessary to achieve this level on a chronic basis to have dysmorphogenesis, but binge drinking achieving this level on any number of days prior to day 85 of pregnancy has the risk of producing such a syndrome.

As to the pathogenesis of alcohol on the fetus, it is known that alcohol equilibrates rapidly across the placenta, and that maternal alcohol that has been degraded to aldehyde is oxidized by placental enzymes before entering fetal blood. Because of the immaturity of fetal enzymes, the fetal blood alcohol level falls at only one-half the rate of the mother, giving rise to the possibility of achieving greater concentrations in fetal blood, as well as having a greater period of time in which to affect the fetus. Ethanol in fetal blood induces severe acidosis and hypoxia,[18] with the most fundamental effects of ethanol being at the level of the cell membrane and the mitochondria, with impaired function of the ATP-activated Na^+-transport system, and impairment of mitochondrial oxidation of fatty acids to carbon dioxide. It also has profound effects on carbohydrate, lipid, and protein metabolism, with decreased rates of leucine incorporation. Decreased levels of ribosomal protein content and total RNA content has been found in fetal livers exposed to ethanol in utero.[19]

The most dramatic effect of maternal alcohol consumption on the fetus is seen in the developing central nervous system. Autopsies were performed on eight offspring exposed to heavy alcohol concentrations in utero. Six of the brains showed widespread malformations resulting from migratory failure of neuronal and glial cells, resulting in multiple heterotopias. The anterior superior gyri were fused through leptomeningeal infiltration, and the cerebral cortex was incompletely developed with relative agyria and large lateral ventricles. Agenesis of the corpus callosum was found, a finding also present in the animal models exposed in utero to ethanol. Some of the structural and functional abnormalities in the fetal alcohol syndrome, such as microcephaly, mental deficiency, and fine motor dysfunction, as well as some of the joint anomalies, may all be secondarily related to the malorientation of the brain caused by the migratory failure described.[20]

Any woman at risk of becoming pregnant should be educated as to the effects of alcohol on the fetus.

Summary

The research on the impact of maternal alcohol consumption on human infants has demonstrated that FAS is clinically observable, with the primary characteristics of pre- and postnatal growth and developmental deficiency, microcephaly, microphthalmia, and cardiac defects.

Because factors other than alcohol, such as nicotine, caffeine, and nutritional intake of vitamins, protein, and trace metals may confound human studies, animal studies have been invaluable. The evidence from the animal studies clearly suggests a risk for adverse outcome of a pregnancy during which alcohol consumption exceeds three ounces of alcohol per day, the equivalent of six drinks, a not uncommon quantity of alcohol among many pregnant women. Further animal experiments must be undertaken to assess the possible risks at lower doses, and longer prospective human studies are necessary to clarify a statistically significant risk

beyond doubt to the fetus exposed to varying doses of alcohol in utero.

The relevance of the recognition and understanding of the fetal alcohol syndrome in the field of obstetrics is obvious. It is important to counsel patients who are known to be chronic alcoholics regarding the risks of pregnancy. Additionally, because the major teratogenic effects of alcohol take place prior to the recognition of pregnancy in many cases, and because binge drinking as well as chronic alcohol consumption can be deleterious, any woman at risk of becoming pregnant should be educated as to the effects of alcohol on the fetus.

While the incidence of fetal alcohol syndrome is at present unknown, conservative estimates show that there are at least one million alcoholic women in the United States, many of child-bearing age. As early as the 1960's, an estimated 21% of women experienced moderate drinking problems, and 4% experienced severe problems. With the markedly increased incidence of alcoholism among teenagers over the last decade, the problems of fetal exposure to the adverse effects of alcohol should not be underestimated.

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Adolescent pregnancy is one of the major medical and social problems in the United States today.

Adolescent Perspectives on Sexuality, Contraception, and Pregnancy

VIRGINIA McNAMARA, M.D., M.P.H., LAUREL ANNE KING, B.S., and MICHAEL F. GREEN, B.A., *Augusta**

Introduction

ADOLESCENT PREGNANCY has continued to occur with a high incidence throughout the nation, and no end seems to be in sight. The United States has an adolescent childbearing rate which ranks fifth among the industrialized nations of the world. It is estimated that 11 million adolescent boys and girls in this country are sexually active. Of the 4 million sexually active female adolescents, 1 million will become pregnant this year. Two-thirds of these adolescent pregnancies are unintended.[1]

Adolescents are extremely vulnerable to the medical complications of pregnancy. Health risks of teenage pregnancy include increased incidences of prematurity, low birth weight, toxemia, labor complications, maternal mortality, fetal and infant mortality, anemia, and neurologic defects.[2]

Social deterrents against out-of-wedlock pregnancy appear to have become nonexistent in today's culture. Out-of-wedlock births showed an increase of 75% in girls aged 14-17 from 1961 to 1974.[3] Out-of-wedlock births have created many social problems which include failure of the mother to remain in school, failure to limit family size, and failure to develop a stable family unit.[4]

About 600,000 adolescent pregnancies were carried to term last year. Approximately 400,000 of these young mothers will be on welfare in the future; thus, adolescent pregnancy also creates an added financial burden for the U.S. taxpayer.[5]

Materials and Methods

In order to better understand the perplexing problem of adolescent pregnancy, we devised a questionnaire relating to adolescent sexual practices, attitudes, and contraception. The questionnaire was reviewed and approved by the Department of Obstetrics and Gynecology, Department of Pediatrics (including the Maternity and Infant Care staff), and Department of Biostatistics of the Medical College of Georgia (MCG).

The patients of the Children and Youth (C&Y) Clinic at MCG were chosen as the target population for the study. The clinic is federally and state funded and provides a wide range of free health services including medical, dental, nursing, social services, and nutrition counseling. In order to be eligible for the clinic services, the children must reside in one of five low-income housing developments in the city of Augusta. Four of the five housing developments consist of black tenants, while the remaining development consists of white tenants.

The interviewers were a female and male medical student who had completed their first year at MCG. Female participants in the study were interviewed by the female medical student at the C&Y Adolescent Gynecology Clinic. Approximately 150 girls receive gynecologic care annually; 50 of these girls were interviewed during clinic visits over a 6-week period.

Due to a decline of male participants in the C&Y Clinic during the summer months, the male medical student found it necessary to go into the housing developments to gather data. Aided by the Adolescent Health Coordinator of the clinic, interviews with male adolescents was arranged and 50 questionnaires were completed.

* Dr. McNamara is Associate Professor, Department of Obstetrics and Gynecology, Medical College of Georgia. Ms. King and Mr. Green are sophomore medical students at the Medical College of Georgia. Dr. McNamara's address is Dept. of Obstetrics and Gynecology, Medical College of Georgia, Augusta, GA 30909.

Discussion of Data

Of the 50 females interviewed, ages ranged from 12 to 19. Of the females, 92% were black, and 8% were white. The ages of the 50 males ranged from 13 to 19. Of the males, 72% were black, and 28% were white.

Sexual Practices

In our study, 96% of the males and 78% of the females said they were sexually active. This is higher than the national figures cited by Sorenson (1973),[6] in which 59% of the males and 45% of the females between the ages of 13 to 19 were sexually active.

The frequency of coitus in this population is higher than the frequency reported by Zelnik and Kantner in 1972.[7] Specifically, 56.4% of the females and 63.3% of the males have sex once a week or more (Table 1-A).

Table 1-B shows that 51.3% of the females and 67.4% of the males have had more than one sex partner; however, this is over a continuum of time. Most participants considered their sex partners to be girlfriends or boyfriends (Table 1-C).

Adolescents in our study began sexual intercourse at an early age. Of the males, 75.5% had their first sexual intercourse at age 14 or below. Of the females, 48.8% had had sex at age 14 or below, but by age 15, 77% have had their first intercourse. In 1973, Sorenson reported that 71% of boys and 56% of girls had already had sex by age 15.[8]

TABLE 1-A — Children & Youth Clinic Study, MCG, 1978

Frequency of Sex	Male	Female
Rarely	24.5%	23.1%
Once a month	12.2%	20.5%
Once a week	42.9%	30.9%
More than 1/week	20.4%	25.6%

TABLE 1-B

No. of Partners	Male	Female
1	32.7%	48.7%
2-3	38.8%	30.8%
3-4	8.2%	12.8%
5 or more	20.4%	7.7%

TABLE 1-C

Who Do You Have Sex With?	Male	Female
Girlfriend/boyfriend	75.5%	94.9%
Friend	48.0%	5.1%
Spouse	0	10.3%
Stranger	16.0%	0

Use and Knowledge of Contraception

A total of 66% of the female participants and 58% of the male participants think that it is the female's responsibility to contracept (Table 3). However, only 40% of the female participants use contraception, and of the 60% not contracepting, 40% never have. Only 38% of the male participants use any form of birth control. The number of adolescents currently using contraception seems low in view of the fact that 86% of the females and 61.2% of the males are aware that free contraception is available at the C&Y Clinic. Many studies have cited ignorance and lack of accessibility as reasons for low contraception usage among adolescents. Based on our findings that contraception is easily accessible to C&Y patients, we strongly disagree with these previous studies. We are not able to postulate any one reason why contraception usage among adolescents in our population is low. However, it may relate to a general lack of concern toward becoming pregnant.

The pill is the most frequently used method of birth control, with 55% choosing this method. (Nationally, 80% of female contraceptors use the pill.[9]) A total of 40% use the IUD. At the C&Y Adolescent Gynecology Clinic, girls are encouraged to use the IUD since many of them do not take the pill as prescribed. Reasons for this include forgetfulness in taking pills, aversion to the side effects (nausea, weight gain, etc.), and a fear of illness. This has resulted in several pregnancies in the C&Y population. A total of 28% of the female participants had been pregnant before, and 42.9% of these were using some form of birth control when they became pregnant. In 83.3% of these cases, the method of birth control was the pill. It is of note that 30% of the non-contracepting females object to using the pill for many of the same reasons previously discussed.

Of the 38% of male participants who use birth control, 89.5% use condoms. Many do so because

TABLE 2 — Children and Youth Clinic Study, MCG, 1978

Use and Knowledge of Contraception	Male	Female
Currently use contraception	38.0%	40.0%
Previously used contraception, if not using now	NA	20.0%
Can get contraception easily	78.0%	90.0%
Where can you get contraception?		
a) C&Y Clinic	61.2%	86.0%
b) Drugstore	28.6%	4.0%
c) All others (health department, etc.)	9.2%	10.0%
Whose responsibility is it to use contraception?		
a) Female alone	58.0%	66.0%
b) Male alone	4.0%	2.0%
c) Both	32.0%	30.0%
d) Neither	4.0%	2.0%

they fear venereal disease. A total of 66% did not object to using condoms, and 84% said they would use condoms if given to them. Use of condoms may be increased by better informing adolescent males of the consequences of venereal disease and the protection offered by condoms. Condoms are a reliable method of contraception for adolescents having infrequent sex, especially if used in conjunction with foam.[10]

Acceptability of Pregnancy

Only 20% of female participants and 16% of male participants favor abortion in the event of pregnancy. In 1977, 20% of pregnant adolescents in the C&Y population had abortions. This is a low number compared with the national estimate of 30.6% of pregnant adolescents obtaining abortions in 1976.[11]

Table 3 shows that 52% of the female participants and 62% of male participants would prefer to have the child and remain single in the event of an unplanned pregnancy. In the United States, the movement toward legal equality for children born out-of-wedlock has been strengthened by laws which permit unmarried mothers and their children to receive social welfare aid. In the C&Y population, we found that out-of-wedlock birth is the rule rather than the exception. Ironically, pregnant teenagers, once ostracized by society, now participate in federal and state funded programs which teach parenting skills and provide complete care for mothers and their babies. Of the males surveyed, 42% would be happy and proud if they got a girl pregnant, while 22% of females would be happy if they got pregnant.

TABLE 3 — Children and Youth Clinic Study, MCG, 1978

Acceptability of Pregnancy— What would you do if you got pregnant or got a girl pregnant	Male	Female
Have baby/remain single	62.0%	52.0%
Get married/have baby	14.0%	16.0%
Have an abortion	16.0%	20.0%
Put up for adoption	6.0%	6.0%

Level of Knowledge of Sex

A total of 70% of the females and 86% of males questioned said they would like to know more about sex (Table 4). This may be due to the fact that the majority of participants considered friends to be their major source of information about sex. We do not consider friends to be a reliable source of information but more often a wealth of misinformation. Because in many instances, a lack of rapport between adolescents and their parents exists, sex education should be mandatory in schools. Only one-fifth of states requiring health education mandate sex education in the schools, and only three-in-ten teachers teach about birth control methods in high school.[12] Dr. Daniel Callahan, Director of the Institute of Society, Ethics, and the Life Sciences sums it up this way: "At the very least, teenagers should have as much knowledge of sex, as many and as good services available, as many choices open to them, as do adults."[13]

TABLE 4 — Children and Youth Clinic Study, MCG, 1978

Level of Knowledge of Sex	Male	Female
Know enough	48.0%	36.0%
Like to know more	86.0%	70.0%

Conclusion

We have examined various aspects of sexuality in our population in an effort to better understand the causes of adolescent pregnancy. The majority of adolescents in the C&Y population are sexually active. They are not good contraceptors, even though they are knowledgeable about birth control. A myriad of reasons for low contraceptive usage among teenagers have been cited in other studies. Our findings strongly suggest that the general lack of concern about getting pregnant may explain the absence of motivation in using contraception.

We believe that the IUD may be the more appropriate method of birth control for adolescents having frequent sex, since many girls do not take the oral contraceptives as prescribed. Condoms and foam may be the more appropriate method of birth control for adolescents having infrequent sex. Our study revealed that most males did not object to using condoms and that many used them because they offered protection from venereal disease.

National interest in adolescent pregnancy has led to the appropriation of funds by Congress for care of pregnant teenagers; however, further increasing the budget to help care for these teenagers is not the solution to the problem of adolescent pregnancy.

It is our finding that adolescent clinics are valuable in the prevention of untimely pregnancy, but even when excellent clinics such as the C&Y Clinic are provided, the pregnancy rate is still high. It is obvious that more must be offered to teenagers than accessible clinics. We propose that family life education in the schools be the cornerstone of every program aimed at the prevention of pregnancy. Such a program would stress not only sexual responsibility but also the concept of the family as a strong social unit. Such a program would ensure that adolescents be fully aware of the demands of parenthood and would emphasize the benefits of delaying pregnancy until one is physically, emotionally, and financially mature.

The prevention of adolescent pregnancies will be assured only when adolescents understand the social value in sexual responsibility and view parenthood in early life as a negative event.

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This study confirms the usefulness of fiberoptic bronchoscopy in a community hospital.

Fiberoptic Bronchoscopy in a Community Hospital

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Abstract

The diagnostic yield and complication rate from flexible fiberoptic bronchoscopy in a community hospital was evaluated. The yield and complication rate in 305 bronchoscopies were similar to those previously reported. This report proves that the results of the procedure done in a community hospital should be equal to those obtained at larger academic institutions.

Introduction

THE FLEXIBLE fiberoptic bronchoscope has revolutionized pulmonary medicine. The rigid bronchoscope and thoracotomy are no longer the primary means of diagnosis for a pulmonary lesion. The fiberoptic bronchoscope has proven extremely useful to the physician dealing with pulmonary medicine in both the larger teaching centers and in the community hospital. The present study was undertaken to assess the results of the technique in a community hospital.

Methods

From June 1974 to February 1978, there were 305 bronchoscopies performed on inpatients in Pulmonary Service of the Department of Internal Medicine at Memorial Medical Center, Savannah, Georgia. These bronchoscopies were performed with the assistance of the Department of Respiratory Therapy. A total of 130 of these procedures were done under flouroscopy in the Radiology Department, and the remaining were performed in the pulmonary function laboratory.

Preoperative laboratory screening included a complete blood count, prothrombin time, activated partial thromboplastin time, platelet count, and arterial gases. All patients had chest x-rays and electrocardiograms. Oxygen was administered if the initial PaO_2 was less than 65 torr.

All patients first received 5 mgs. valium and 0.5 mgs. atropine intramuscularly. They were then bronchoscoped transnasally without an airway. A solution of 22-24 ml. of a 2% lidocaine was administered via a compressed air powered atomizer to the nose and oropharynx to anesthetize the vocal cords and the upper tracheobronchial tree. Additional small increments of this solution were administered throughout the procedure.

Results

The final diagnosis in all 305 patients is listed in Table 1. We divided the patients into five groups, according to their type of disease: Group I, Bronchogenic carcinoma; Group II, Metastatic carcinoma; Group III, Diffuse or localized pulmonary infiltrates; Group IV, Therapeutic — atelectasis, etc.; and Group V, Miscellaneous, i.e. without x-ray abnormality, encompassing diagnosis of bronchitis, vocal cord pathology, etc. or with x-ray abnormality — recurrent pneumonia.

Group I — Bronchogenic Carcinoma

There were 57 cases of suspected bronchogenic carcinoma of the lung (Table 2). A total of 56 of these cases were confirmed. Twenty of the 23 lesions

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visible through the scope were confirmed on either brushing or biopsy for a yield of 87% There were 34 patients whose tumors were not visible through the bronchoscope and who required fluoroscopic control for placement of the brush and biopsy forceps. Two patients were early in the study and did not have flouroscopic control. Twenty-two of the peripheral bronchogenic carcinomas were diagnosed via bronchoscopy, for a yield of 65%. The combined group of 57 suspected bronchogenic carcinomas had a positive diagnosis in 42 patients (78%).

Group II — Metastatic Carcinoma

There were 14 patients who had metastatic carcinoma to the lung. These were comprised mostly of carcinoma of the breast or colon. There were several

TABLE 1 — Diseases Encountered in 305 Patients Who Had Fiberoptic Bronchoscopy, Memorial Medical Center, Savannah, Georgia, 1974-1978

Disease	Number of Patients
Pneumonia	51
Lung Abscess	15
Atelectasis	19
Ventilation—Therapeutic or Diagnostic	19
Bronchitis	35
Carcinoma (Bronchogenic)	56 confirmed; 1 probable
Sarcoid	10
Tuberculosis	14
Metastatic Carcinoma	14 (5 tumor emboli)
Fungal Disease	
Mucor	1
Aspergillus	3
Petrielidium	1
Candida	1
Nocardia	2
Cryptococcosis	4
Interstitial Fibrosis	17
Vocal Cord Pathology	3
Pulmonary Emboli	3
Bronchitis & Bronchiolectasis	2
Granuloma—No Diagnosis	4
Cystic Fibrosis	2
Bronchostenosis & Bronchiectasis	18
Tracheal Stenosis	4
Inactive Tuberculosis	5
Lymphoma	3
Post Resection Carcinoma	6
Bronchial Adenoma	2
Lipoid Pneumonia	2
Radiation Fibrosis	2
Paralyzed Diaphragm	3
Miscellaneous	
(1) Wegener's Granulomatosis	1
(2) Tularemia	1
(3) Hypersensitivity Pneumonia	1
(4) Unexplained Pleural Effusion	1
(5) Pleural Reaction	1
(6) Idiopathic Alveolar Hemorrhage	1
(7) Hemangioma	1
(8) Hemoptysis—unexplained	1
(9) Cytomegalovirus	1
(10) Hodgkin's Disease	1
(11) Silicosis	1

TABLE 2 — Yield From Fiberoptic Bronchoscopy in Bronchogenic Carcinoma

	Number of Patients	Positive Diagnosis	% Yield
Tumor visible	23	20	87
Tumor not visible (Fluoroscope used)	34	22	65
Total	57	42	83

malignant melanomas. In this group, there were only three positive diagnoses (22%) by bronchoscopy with brushing and biopsy. Five of the 14 patients had tumor emboli as the sole manifestation of their metastatic process. In these patients, it was extremely difficult to make the diagnosis with this approach.

Group III — Diffuse or Localized Pulmonary Infiltrates

There were 94 patients with diffuse or localized infiltrative pulmonary disease. A total of 72 of these patients were diagnosed with transbronchial biopsy and/or bronchial brushing, for a yield of 77%. In 80 patients, the results of bronchoscopy correlated with other clinical findings assisted in making the diagnosis. Therefore, the results of bronchoscopy with appropriate brushing and biopsy provided some clinical information that was helpful in making or definitely establishing a diagnosis in 85% of the total 94 patients.

Group IV — Therapeutic

A total of 36 bronchoscopies were performed for therapeutic purposes. Nineteen of these were for treatment of atelectasis, and 17 were done on patients on ventilators for respiratory failure. Fifteen patients had lung abscesses and were bronchoscoped to facilitate drainage.

Group V — Miscellaneous

The remaining bronchoscopies were performed on a mixed population of patients, some of whom had pulmonary symptoms in conjunction with a negative chest x-ray. In this group, fiberoptic bronchoscopy was of extreme importance in diagnosing such conditions as bronchitis and tracheal and bronchial stenosis, etc. It was also of value in contributing some information in the diagnoses of diseases such as bronchiectasis. Another group of patients had the procedure performed to evaluate the bronchial tree in recurrent pneumonias. Two bronchial adenomas were found in this group.

Discussion

Since the introduction of the fiberoptic bronchoscope by Ikeda,[1] its advantages over the rigid bronchoscope have become obvious. It is easier to use,

permits greater maneuverability, has extended the range of vision to the subsegmental bronchi and beyond, is more acceptable to the patient, provides increased precision in diagnoses, and has a very low complication rate.[2] It has become even more useful with the advent of the transbronchial biopsy as a means of diagnosing diffuse pulmonary diseases.[3, 4]

In this study at a 465-bed community hospital, fiberoptic bronchoscopy with brush and biopsy was the preferred technique for diagnosis of any lung lesion, diffuse or localized. The only exceptions were mediastinal disease with no tracheobronchial or pulmonary involvement and the peripheral subpleural nodule.

Contraindications to fiberoptic bronchoscopy included: (1) poor patient cooperation; (2) uncorrected bleeding diathesis; (3) PaO_2 less than 65 torr with O_2 administration; (4) $PaCO_2$ greater than 50 torr; (5) serious cardiac arrhythmias; (6) recent myocardial infarction; and (7) acute asthma. Azotemia and thrombocytopenia, particularly in the patient on cytotoxic and immunosuppressive therapy, placed the patient in a higher risk group.

In a series of 360 cases of bronchogenic carcinoma, Ikeda found 140 lesions with the fiberoptic bronchoscope which could not be seen with the rigid scope.[5] Keith et al. confirmed these findings.[6] The diagnostic yield of endoscopically visible lesions has been well documented in the literature, with approximately 90% reported by various authors.[7, 8] In our Group I patients with endoscopically visible lesions, a positive diagnosis was made in 87%. One case in which a correct diagnosis was not made was also unable to be diagnosed on rigid bronchoscopy, and another case was never confirmed with a tissue diagnosis.

The experience with diagnosis of peripheral lesions not directly visualized during fiberoptic bronchoscopy has also been significant. Positive diagnosis under flouroscopic control has been achieved from 66% to 78% in various studies.[8, 9] In our group of 34 patients with peripheral bronchogenic carcinoma, a positive diagnosis was made in 65% with the aid of fluoroscopy. These results compare favorably with those studies previously mentioned. The lower yield for these lesions is not surprising, since the standard brush and biopsy forceps lack directional control at the tip, and correct placement is often difficult to achieve. The overall yield of 78% in both peripheral and central carcinomas is comparable to similar results at the large academic training centers.

Kvale et al. have reported the failure of bronchial washings and post bronchoscopy sputum examinations to significantly alter the yield from fiberoptic bronchoscopy in bronchogenic carcinoma.[10] Our experience was similar in that only one positive diagnosis in 57 bronchoscopies was made in this fashion with associated negative biopsy and brushing.

In our Group II patients with metastatic carcinoma to the lungs, the yield decreased significantly. All of the procedures in these patients were done under fluoroscopy and had relatively small peripheral lesions or interstitial metastatic lesions. In this group, we had a positive diagnosis in 22%, compared to 38% in other investigations.[11] The lower yield in our series can be attributed to the lack of biplanar fluoroscopy in our hospital and to the unusual circumstance of five patients with tumor emboli as their sole manifestation of pulmonary metastases amongst our 14 patients. All five of these patients had negative results as one might anticipate. Zavala[11] has demonstrated that, in patients with metastatic carcinoma to the pulmonary parenchyma, the transbronchial biopsy technique provides a higher diagnostic yield than brushing. The majority of our patients were treated with brushing alone prior to development of transbronchial biopsy techniques, which further explains our lower yield.

In our Group III patients with diffuse or localized infiltrative disease excluding carcinoma, we achieved a yield of 77% positive diagnoses. Joyner and Scheinhorn and Ellis reported a pathological diagnosis obtained via fiberoptic bronchoscopy and transbronchial biopsy in 70% and 79%, respectively, in diffuse lung disease.[12, 13]

Our Group III patients were comprised of a very mixed population of diseases. Among the more common were tuberculosis, interstitial fibrosis, sarcoid and several fungal processes. Only patients with pneumonia that failed to respond to therapy or those whose disease etiology was not apparent were bronchoscoped, brushed, and biopsied. There were several patients who were done early in our experience before routine use of transbronchial biopsies. This prevented us from making the proper diagnosis, since brushing alone could not make the diagnosis in lipoid pneumonia, silicosis, hypersensitivity pneumonia, etc. This undoubtedly affected our results and prevented our yield from being greater.

Koerner et al. recently demonstrated the value of this procedure in patients with sarcoidosis. He obtained a positive diagnosis in 21 out of 23 patients.[14] Koontz et al. had a 63% yield in patients with sarcoid.[15] In our Group III patients with sarcoid, a diagnosis was made via transbronchial biopsy in six out of seven patients (86%).

Six of the 94 patients in Group III were subjected to thoracotomy for diagnosis. Three of these patients were found at surgery to have similar pathological processes as demonstrated on transbronchial biopsy. However, they were sent for surgical confirmation, since the transbronchial biopsies were felt to be

compatible but not adequate enough to make a definitive diagnosis. These three patients had diagnoses of Wegener's granulomatosis, post viral bronchiolectasis, and usual interstitial fibrosis. Two of the remaining three were done early in the series and were brushed only. These patients had Caplan's Syndrome and lipoid pneumonia, making it impossible to make a diagnosis without a transbronchial biopsy.

There were 36 bronchoscopies performed in Group IV for therapeutic purposes to facilitate drainage from lung abscesses, to treat atelectasis, or to remove thick, tenacious secretions on ventilator patients. Lindholm et al. have documented the value of the fiberoptic bronchoscope in the management of atelectasis in patients in respiratory failure.[16] They demonstrated clearing in 81% of patients with visible retained secretions. Nineteen of the bronchoscopies in Group IV were performed for treatment of atelectasis; 17 of these were done while the patient was on the ventilator. One patient with a high cervical cord lesion had five therapeutic bronchoscopies for recurrent atelectasis before he was successfully weaned from the ventilator. There were 15 patients bronchoscoped for drainage and irrigation of lung abscesses. All of these patients tolerated the procedure well, and no complications were encountered.

The remaining patients comprised Group V and were a heterogeneous group consisting primarily of cases of bronchitis, bronchiectasis, tracheal stenosis, and other conditions. Two bronchial adenomas with negative chest x-rays were discovered in this group.

There were several patients who were found to have more than one diagnosis, i.e. bronchiectasis and nocardiosis, bronchostenosis with tuberculosis and cryptococcosis in a bronchiectatic segment, etc.

Complications

One remarkable aspect of fiberoptic bronchoscopy is the exceedingly low complication rate of less than 0.1%[2]. There were no complications from parenteral premedication or local anesthesia in this series. The rate of significant complications was 1% for all bronchoscopies. One patient died immediately following a bronchoscopy for suctioning and localization of pulmonary hemorrhage while on a ventilator with PEEP. This patient was in critical condition at the initiation of the procedure. The remaining significant complications were limited to two patients (2%) who developed pneumothorax following transbronchial biopsy. The incidence of this has been reported from 1-4% in other studies.[12, 13] One patient had hemoptysis of approximately 50 ml. of blood following transbronchial biopsy. This stopped spontaneously and did not present a major problem. Two patients experienced a transient rise in temperature which returned to normal in 24 hours.

Conclusion

Flexible fiberoptic bronchoscopy has had a dramatic impact on pulmonary medicine. The procedure can be performed in a community hospital as well as in the larger academic institutions. This report provides ample evidence that it can be performed as well and with the same degree of safety in the community hospital. However, it is mandatory to have a pathology department skilled in handling and interpreting the material obtained. Similarly, a good support team such as our department of respiratory therapy is also vital. In conclusion, this study confirms the usefulness of fiberoptic bronchoscopy in a community hospital.

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A statistical analysis and discussion of the effectiveness of smoking withdrawal clinics operated by the Atlanta Lung Association.

An Evaluation of a Smoking Withdrawal Clinic

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Introduction

THIS STUDY was conducted to evaluate the effectiveness of the smoking withdrawal clinics operated by the Atlanta Lung Association since 1973. The statistical analysis was based on data from five consecutive clinics in 1976-1977, ranging in size from 34 to 86 smokers in each, with a total of 325 individuals participating. The age, sex, and marital status were the variables considered in the analysis. The largest percentage of people were in the 30 to 39 age group. Of those who attended these clinics, 63% (205 of 325) said they stopped smoking. At the end of 1 year, 54% (110 of 205) of those who had stopped smoking at the end of the clinic were still not smoking. Discriminant function analysis showed that as age increases a person is more likely to abstain from smoking longer. In addition, married, divorced, and widowed people are more likely to abstain from smoking longer than single people. The young single male is not often motivated to want to stop smoking; however, of those individuals who attended the clinics, the sex of the participant did not seem to affect the results.

A review of relevant literature indicates rather poor long-term results from smoking withdrawal clinics.[1-5] In this study the effectiveness of this smoking withdrawal clinic was evaluated in terms of the following questions: How long do people remain non-smokers once they have stopped, and which ones restart the habit? How are sex, age, and marital status related to the motivation of people to attend the clinics, and how do these factors affect the dropouts (those who start smoking again)?

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Materials and Methods

The clinics are six 1-hour sessions completed in 1 week, with the first five using the film prepared by the Temperance Department of the Seventh-day Adventist Church, "Five-day Plan to Stop Smoking." This plan uses a buddy system and a group psychotherapeutic approach to develop the necessary willpower to stop smoking. This method has been widely accepted and used all over the world.[3-4] These sessions include lectures or discussions on the psychologic aspects of smoking and also films on smoking and its harmful effects on the body and mind. Demonstrations of procedures helpful in overcoming the smoking habit without drugs are a part of the program, as is an exchange of experiences by participants as they fight the habit.

This is a personal control program that reaches into every minute of the individual's waking life during this week. A special booklet entitled "Your Five-day Plan" tells how to relax and how to avoid familiar spots or activities that might lead to a smoke. It tells him when to exercise and how to breathe, what to eat and drink, and even what to think at crucial times. The program assists the participant in dealing with the habit of smoking on a physical, mental, social, and spiritual basis.

This program differs from the "Five-day Plan" in several important ways. The director of the clinic makes regular post clinic follow-up contacts with the participants by telephone, and knows each participant on a first-name basis.

Another way in which this program differs is that there are six sessions — five on consecutive days and the last on the eighth day. At this sixth session the enrollees are encouraged to talk about their successes and failures. The informal discussions appear to be beneficial in developing friendships and at the same time encourage the non-smoking habit. The meeting

TABLE 1 — Results of 5 Stop-Smoking Clinics Involving 325 Participants, Atlanta Lung Association, 1976-1977

Result	Number	Percent
Reported to have stopped smoking at the end of the clinic	205	63
Did not stop smoking	120	37
Dropouts (smoking again) after 3 months	43	13
Dropouts (smoking again) after 6 months	22	7
Stopped smoking 1 year or longer	110	34
Lost contact and are considered dropouts (smoking)	30	9

develops into a pleasant social occasion, and this socialization makes it possible for the director to make the follow-up contacts on a first-name basis.

Results

The analysis is based on data from five consecutive clinics ranging in size from 34 to 86 smokers each, with a total participation of 325 individuals. The age, sex, and marital status were the variables considered in the analysis.

As can be seen in Table 1, 120 participants never did stop smoking, and 30 are presumed to be smoking since they have not been contacted. Thirty-four percent (110 of 325) stopped smoking for more than a year, and 54% (110 of 205) of those who reported to have stopped smoking at the end of the clinic are still not smoking one year later.

Table 2 shows the age, sex, and marital status of the 110 individuals who were not smoking a year or more after the clinics.

Tables 3 and 4 show the age, sex, and marital status of those who are known to have started smoking again after 3 and 6 months, respectively. The majority of those who started smoking again were in the 30-39 age group, with the second largest number in the 20-29 group. The largest number of both sexes who resumed smoking were married; this was especially true of the men.

Table 5 is a study of the 120 individuals who attended the clinics but did not stop smoking. Most of these persons were married, and the men who failed to stop smoking tended to be older with 70% (40 of 57) in the ages of 40-59.

TABLE 2 — Non-smokers — After 12 Months, by Age, Sex, and Marital Status, Atlanta Lung Association, 1976-1977

	Women (Marital Status)					Men (Marital Status)				
Age	S	M	W	D	Total	S	M	W	D	Total
20-29	9	6	—	2	17	—	7	—	—	7
30-39	1	26	2	—	28	—	12	—	—	12
40-49	1	14	—	2	17	—	16	1	—	17
50-59	—	1	4	1	6	—	5	1	—	6
Total	11	46	6	5	68	—	40	2	—	42

TABLE 3 — Persons Who Started Smoking Again After 3 Months Cessation, by Age, Sex, and Marital Status, Atlanta Lung Association, 1976-1977

	Women (Marital Status)					Men (Marital Status)				
Age	S	M	W	D	Total	S	M	W	D	Total
20-29	5	7	—	1	13	1	3	—	—	4
30-39	1	8	—	1	10	3	8	—	—	11
40-49	—	1	—	1	2	1	1	—	—	2
50-59	—	1	—	—	1	—	—	—	—	—
Total	6	17	—	3	26	5	12	—	—	17

TABLE 4 — Persons Who Started Smoking Again After 6 Months, by Age, Sex, and Marital Status, Atlanta Lung Association, 1976-1977

	Women (Marital Status)					Men (Marital Status)				
Age	S	M	W	D	Total	S	M	W	D	Total
20-29	2	1	—	—	3	—	1	—	—	1
30-39	—	5	—	1	6	—	7	—	—	7
40-49	—	2	—	—	2	—	2	—	—	2
50-59	1	—	—	—	1	—	—	—	—	—
Total	3	8	—	1	12	—	10	—	—	10

A lack of motivation is given by 62% (40 of 65) of persons who restarted smoking after 3 and 6 months (Tables 6 and 7). It is realized that this reason could cover or include almost all other reasons. Thirty-four percent (13 of 38) of the women said they resumed smoking because of gaining weight. None of the men used this reason for having returned to smoking. Fourteen percent (9 of 65) started smoking again when some other illness, accident, or physical problem developed.

Follow-up contact of the clinic participants were made at four intervals: less than three months; 3-6 months; 6-12 months; and 12+ months.

The statistical technique of discriminant analysis was used to determine if four groups were different on the basis of the variables in this study. For the four groups of people who stopped smoking for different lengths of time, the statistical analysis indicates that they could be differentiated on the three variables. The most important variable in the discriminant

TABLE 5 — Persons Who Did Not Stop Smoking, By Age, Sex, and Marital Status, Atlanta Lung Association, 1976-1977

	Women (Marital Status)						Men (Marital Status)				
Age	S	M	W	D	Total	Age	S	M	W	D	Total
Less than 20	2	—	—	—	2	Less than 20	1	—	—	—	1
20-29	8	2	1	—	11	20-29	2	4	—	—	6
30-39	3	14	1	2	20	30-39	—	9	1	—	10
40-49	—	11	3	8	22	40-49	—	13	2	5	20
50-59	—	—	4	1	4	50-59	—	13	4	3	20
Over 60	—	1	2	1	4	Over 60	—	—	—	—	—
Total	13	28	11	11	63	Total	3	39	7	8	57

TABLE 6 — Reasons for Restarting Smoking After 3 Months, by Sex and Age, Atlanta Lung Association, 1976-1977

Age	Domestic or Marital Problems	Illness	Lack of Motivation	Gained Weight	Total
			Women		
20-29	—	—	8	5	13
30-39	1	1	5	3	10
40-49	—	—	2	—	2
50-59	—	—	1	—	1
Total	1	1	16	8	26
			Men		
20-29	—	1	3	—	4
30-39	1	2	8	—	11
40-49	—	—	2	—	2
50-59	—	—	—	—	—
Total	1	3	13	—	17

TABLE 7 — Reasons for Restarting Smoking After 6 Months, by Sex and Age, Atlanta Lung Association, 1976-1977

Age	Domestic or Marital Problems	Illness	Lack of Motivation	Gained Weight	Total
			Women		
20-29	1	—	—	—	1
30-39	—	—	1	2	3
40-49	—	1	—	3	4
50-59	—	—	4	—	4
Total	1	1	5	5	12
			Men		
20-29	—	—	2	—	2
30-39	—	1	1	—	2
40-49	—	2	3	—	5
50-59	—	1	—	—	1
Total	—	4	6	—	10

analysis was age. The older a person was, the longer he was able to abstain from smoking. Marital status was the second highest variable. Married, divorced, and widowed people were more likely to abstain from smoking longer than single people. The third variable, sex of the participant, contributed very little to the discriminant analysis, and therefore does not seem to affect whether one stops smoking or not.

Discussion

In the evaluation of five smoking withdrawal clinics conducted by the Atlanta Lung Association in 1976-1977, a total of 63% of those who attended the clinics quit smoking. At the end of 1 year, 54% of those who had stopped smoking at the end of the clinic (or 34% of those who attended) were still successfully off cigarettes.

Our greatest challenge at this point is to learn better methods of increasing motivation among smokers to quit. Motivation seemingly comes with a gradual educational process and is influenced by previous experiences, peer pressure, community health programs, and general awareness of the dangers of smoking. The importance of an enthusiastic director who maintains a helpful relationship to the clients cannot be overemphasized.

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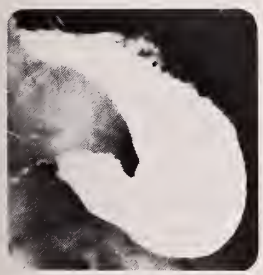
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In this double-blind study, twenty patients having G.I. series and exhibiting spasm were randomly selected to receive either 2 cc. of Bentyl or sodium chloride intramuscularly. Ten minutes after the injection another radiograph was taken . . .

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*This drug has been classified "probably" effective in treating functional bowel/irritable bowel syndrome.

†See Warnings, Precautions and Adverse Reactions.

See following page for prescribing information.

Reference:
King, J.C. and Starkman, N.M.: Evaluation of an antispasmodic. Double-blind evaluation to control gastrointestinal spasms occurring during radiographic examination. A preliminary report. Western Med. 5:356-358, 1964.

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Brief Summary

INDICATIONS

Based on a review of this drug by the National Academy of Sciences–National Research Council and/or other information, FDA has classified the following indications as "probably" effective:

For the treatment of functional bowel/irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis.

THESE FUNCTIONAL DISDRDERS ARE OFTEN RELIEVED BY VARYING CDMBINATIDNS OF SEDATIVE, REASSURANCE, PHYSICIAN INTEREST, AMELIDRATIDN DF ENVIRONMENTAL FACTORS.

For use in the treatment of infant colic (syrup).

Final classification of the less-than-effective indications requires further investigation.

CONTRAINDICATIDNS: Obstructive uropathy (for example, bladder neck obstruction due to prostatic hypertrophy); obstructive disease of the gastrointestinal tract (as in achalasia, pyloroduodenal stenosis); paralytic ileus, intestinal atony of the elderly or debilitated patient; unstable cardiovascular status in acute hemorrhage; severe ulcerative colitis; toxic megacolon complicating ulcerative colitis; myasthenia gravis. WARNINGS: In the presence of a high environmental temperature, heat prostration can occur with drug use (fever and heat stroke due to decreased sweating). Diarrhea may be an early symptom of incomplete intestinal obstruction, especially in patients with ileostomy or colostomy. In this instance treatment with this drug would be inappropriate and possibly harmful. Bentyl may produce drowsiness or blurred vision. In this event, the patient should be warned not to engage in activities requiring mental alertness such as operating a motor vehicle or other machinery or perform hazardous work while taking this drug. PRECAUTIONS: Although studies have failed to demonstrate adverse effects of dicyclomine hydrochloride in glaucoma or in patients with prostatic hypertrophy, it should be prescribed with caution in patients known to have or suspected of having glaucoma or prostatic hypertrophy. Use with caution in patients with: Autonomic neuropathy. Hepatic or renal disease. Ulcerative colitis. Large doses may suppress intestinal motility to the point of producing a paralytic ileus and the use of this drug may precipitate or aggravate the serious complication of toxic megacolon. Hyperthyroidism, coronary heart disease, congestive heart failure, cardiac arrhythmias, and hypertension. Hiatal hernia associated with reflux esophagitis since anticholinergic drugs may aggravate this condition.

Do not rely on the use of the drug in the presence of complication of biliary tract disease. Investigate any tachycardia before giving anticholinergic (atropine-like) drugs since they may increase the heart rate. With overdosage, a curare-like action may occur. ADVERSE REACTIONS: Anticholinergics/antispasmodics produce certain effects which may be physiologic or toxic depending upon the individual patient's response. The physician must delineate these. Adverse reactions may include xerostomia; urinary hesitancy and retention; blurred vision and tachycardia; palpitations; mydriasis; cycloplegia; increased ocular tension; loss of taste; headache; nervousness; drowsiness; weakness; dizziness; insomnia; nausea; vomiting; impotence; suppression of lactation; constipation; bloated feeling; severe allergic reaction or drug idiosyncrasies including anaphylaxis; urticaria and other dermal manifestations; some degree of mental confusion and/or excitement, especially in elderly persons; and decreased sweating. With the injectable form there may be a temporary sensation of lightheadedness and occasionally local irritation. DOSAGE AND ADMINISTRATION: Dosage must be adjusted to individual patient's needs.

Usual Dosage: Bentyl 10 mg. capsule and syrup: *Adults:* 1 or 2 capsules or teaspoonfuls syrup three or four times daily. *Children:* 1 capsule or teaspoonful syrup three or four times daily. *Infants:* ½ teaspoonful syrup three or four times daily. (May be diluted with equal volume of water.) Bentyl 20 mg.: *Adults:* 1 tablet three or four times daily. Bentyl Injection: *Adults:* 2 ml. (20 mg.) every four to six hours intramuscularly only. NDT FDR INTRAVENDUS USE. MANAGEMENT DF DVERDOSE: The signs and symptoms of overdose are headache, nausea, vomiting, blurred vision, dilated pupils, hot, dry skin, dizziness, dryness of the mouth, difficulty in swallowing, CNS stimulation. Treatment should consist of gastric lavage, emetics, and activated charcoal. Barbiturates may be used either orally or intramuscularly for sedation but they should not be used if Bentyl with Phenobarbital has been ingested. If indicated, parenteral cholinergic agents such as Urecholine® (bethanecol chloride USP) should be used.

Product Information as of October, 1978.

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The scintiangiographic study offers a unique method for demonstrating filling defects in the right atrium and perhaps other cardiac chambers.

Echocardiographic and Scintiangiographic Observations in a Patient With a Right Atrial Myxoma

STEPHEN D. CLEMENTS JR., M.D., B. WOODFIN COBBS JR., M.D., JOHN V. PERKINS, SPENCER B. KING, M.D., J. THEODORE WINGARD, M.D., and JOSEPH M. CRAVER, M.D., *Atlanta

THE RIGHT ATRIAL MYXOMA remains a difficult diagnosis. The tumor is usually diagnosed when it has reached large size and obstructs flow through the tricuspid orifice. Sometimes the entire right atrium is filled with tumor mass resulting in a clinical situation resembling constrictive pericarditis, massive pulmonary embolization, tricuspid stenosis, or superior vena cava obstruction.

M-mode echocardiography has offered another non-invasive method to aid in the diagnosis of this treatable condition, as have radionuclide blood pool scans. We have recently seen a patient with a large right atrial myxoma who presented with an interesting clinical situation and whose diagnosis was suspected from M-mode echocardiography and hepatic scintiangiographic studies and later confirmed by radiopaque angiography and surgery.

Case Presentation

The patient was a 74-year-old woman who presented to the urology service at the Emory University Hospital because of a renal cyst, abdominal swelling, and ankle edema. Her abdomen and extremities had gradually become swollen over the last several months. She had prominent exertional dyspnea, but was comfortable at rest and had no orthopnea.

On physical examination, jugular venous pressure was tremendously elevated and constant without pulsation, even with the patient in the standing position.[1] An apparent diastolic friction rub, and a brief slight squeaking sound indicated heart disease. Liver edge was palpable at the umbilicus. Moderate pitting pretibial edema was present.

Electrocardiogram showed peaked p waves, vertical axis, and low voltage. Chest x-ray showed elevated right hemidiaphragm and mild generalized cardiomegaly.

Echocardiogram showed incomplete echoes from the anterior tricuspid valve leaflet (Figure 1). Behind the anterior leaflet in diastole multiple echoes from the prolapsing tumor were noted. These did not follow the anterior tricuspid leaflet to the extent of its excursion and did not flatten the E-F slope. An echo-free space behind the anterior tricuspid leaflet in early diastole was not present. In systole, the tumor echoes disappeared into the atrium. Paradoxical motion of the interventricular septum was present.

As part of a liver scan, hepatic scintiangiography was done after a 0.3 ml bolus injection of 2 mCi of ^{99m}Tc sulfur colloid into a peripheral vein.[2] An automatic camera was activated in order to obtain 3 second exposures over approximately the next 40 to 60 seconds. Images from the thorax including the superior vena cava, right atrium, and ventricle were easily identified on the upper portion of the film. The images were not gated with the surface electrocardiogram, since it was not a routine cardiac blood

* Drs. Clements, Cobbs, King, and Mr. Perkins are from the Division of Cardiology, Department of Medicine, and Drs. Wingard and Craver are from the Division of Thoracic and Cardiovascular Surgery, Emory University School of Medicine, Emory University Hospital, Atlanta, GA. Address reprint requests to Dr. Clements, Emory University Clinic, 1365 Clifton Rd., NE, Atlanta, GA 30322.

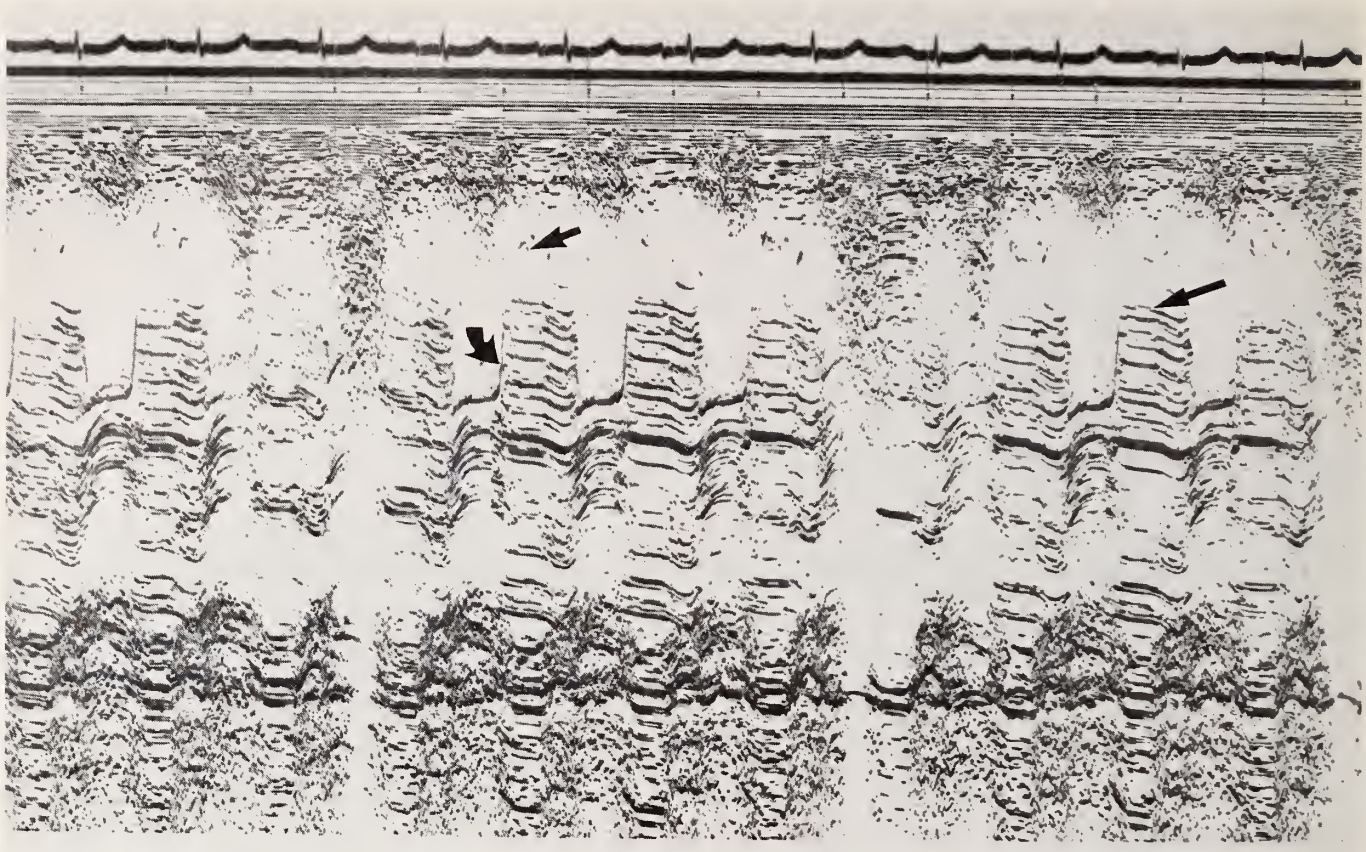


Figure 1 — Echocardiogram shows opening of the anterior tricuspid leaflet (curved arrow), with no echo-free space immediately behind, and incomplete echoes during most of diastole (short straight arrow). Tumor echoes do not prolapse the full extent of valve excursion and produce layers of echoes (long straight arrow).

pool scan. A mobile filling defect was present in the right atrium and no inferior vena cava flow was noted (Figure 2).

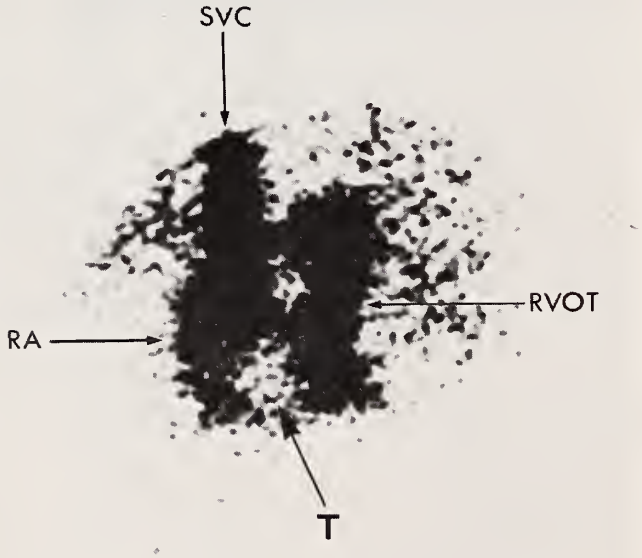


Figure 2 — One exposure of a scintiangiogram shows radioactivity in the superior vena cava (SVC), right atrium (RA), right ventricle and outflow tract (RVOT), and pulmonary artery. At the junction of right atrium and right ventricle, there is a filling defect produced by the tumor (T).

A catheter was introduced into the superior vena cava and radiopaque contrast was injected, demonstrating a large tumor mass filling the atrium and moving into the tricuspid orifice in diastole (Figure 3). Subsequently, an 11 by 8 cm tumor was removed from the atrium with other fragments extracted from the inferior vena cava. The tumor was noted to be attached to the floor of the right atrium occluding and invading the walls of the inferior vena cava and hepatic veins, with thrombosis of the remaining vena cava, iliac, and common femoral veins bilaterally (Figure 4).

Discussion

Only a few echocardiographic studies of patients with right atrial myxoma appear in the literature. There is considerable variation in the echocardiographic patterns observed. One of the first studies described by Wolfe[3] was very similar to our case. In his study, there was also difficulty in obtaining a complete echo from the anterior tricuspid leaflet. No clear space was obvious behind the valve as the tumor mass prolapsed through the tricuspid orifice. A change in the ultrasound controls could certainly have obscured these rather weak echoes. Our patient's tumor reflected echoes in layers, whereas the tumor reported by Wolfe reflected a cloud of echoes.



Figure 3 — One frame of a radiopaque cineangiogram showing a large filling defect in the right atrium (short arrows define borders). SVC = superior vena cava; RVOT = right ventricular outflow tract.

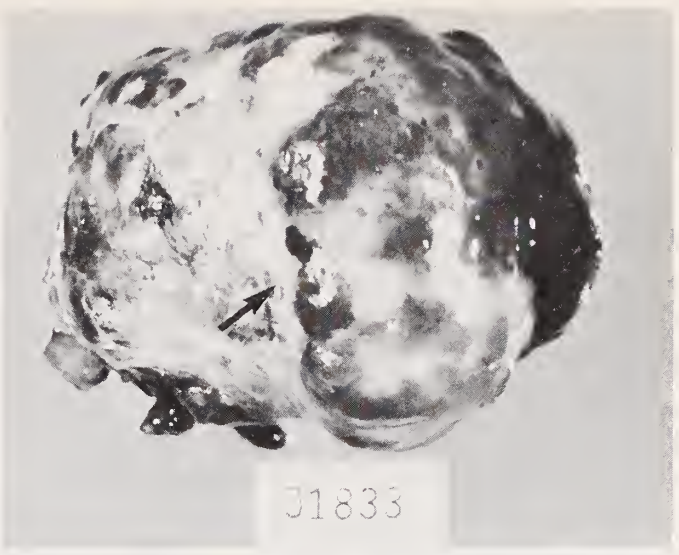


Figure 4 — The surgical specimen after removal measured 11 by 8 cm and was multilobulated. Arrow indicates equator-like band of fibrous tissue probably resulting from friction between the prolapsing tumor and the tricuspid annulus.

A report by Goldschlager demonstrated a relatively thin moving mass with a questionable relationship to the tricuspid valve.[4] Although the mass on echo appeared small, on angiography it was very similar to that of our patient.

Waxler reported a patient with a right atrial myxoma that produced abnormal echoes in systole and diastole.[5] The tricuspid valve leaflets were not well defined in this study. Harbold studied a patient with a tumor prolapsed through the valve orifice in late diastole and persisted into the first one-third of systole.[6] This mass produced a cloud of echoes with some layering effect. In the echo reported by Harbold the tricuspid valve leaflets are not well identified, and therefore a search for clear space is not applicable. The delayed appearance of the tumor in the right ventricle certainly means that an echo-free space would be expected behind the tricuspid leaflet prior to the tumor prolapsing through the tricuspid orifice. Other reports also demonstrate clouds of echoes prolapsing into the right ventricle in diastole.[7-12]

Our patient's tumor was clearly defined and was associated with incomplete anterior tricuspid leaflet echoes. The tumor did not prolapse completely through the tricuspid orifice leaving the equator of the tumor still in the atrium. Thus, the E-F slope of the tricuspid valve was normal. On initial inspection on the oscilliscope, one might confuse these echoes with motion artifact from breathing, and thus they might not be recorded. Timing with the QRS complex identifies these echoes as a moving intracardiac mass. The tumor produced layers of echoes that could be eliminated with near gain controls but clearly represented an important structure, the tumor. There was no clear space behind the tricuspid leaflet, indicating the tumor promptly followed and was in contact with the anterior tricuspid leaflet. The tumor completely disappeared from the echo beam in systole.

Our case was somewhat unique in that the tumor extended into the inferior vena cava and hepatic veins. It was difficult to determine where the tumor ended and thrombosis began.

The echocardiographic diagnosis depends on a high index of suspicion, appropriate control settings, and transducer position. Variable patterns of motion can be seen in relationships to the cardiac cycle. Some tumors produce clouds of echoes and others apparently return echoes in a layered pattern. Recognition of these patterns should be helpful in the echocardiographic diagnoses of right atrial myxoma.

The scintiangiographic study offers a unique method for demonstrating filling defects in the right atrium and perhaps other cardiac chambers. This is best performed by using a radionuclide gated blood pool scan.[13, 14] It clearly showed the tumor mass when viewed in a dynamic fashion and had an identical appearance to the radiopaque cineangiogram. As demonstrated in a recent report, the combination of the M-mode echocardiogram and the radionuclide blood pool scan offers good diagnostic information about presence of right atrial myxoma.[15] Perhaps two dimensional echocardiography will add even more.

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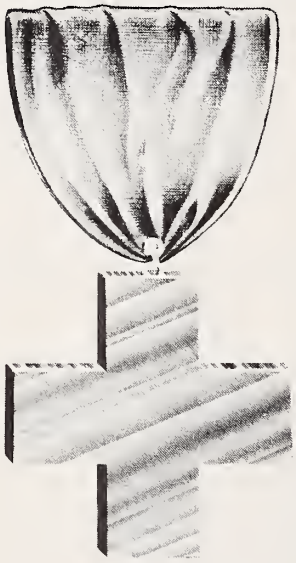
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Passengers received the best treatment on the three voyages headed by Oglethorpe, who was sincerely interested in the health of each passenger.

The Voyage: A Study of Medical Hazards on the First Immigrant Ships to Georgia

GERALD L. CATES, Ph.D., *Cleveland**

For many of America's first colonists, their most harrowing experiences were associated with getting to the New World. They often spent 8 to 12 weeks packed into cramped wooden ships, being tossed and pummeled by the turbulent Atlantic. The suffering encountered during such voyages frequently resulted in the deaths of many colonists before they reached their new homes. The Marxist historian, Eric Williams, has compared the mortality of such immigrant ships to that on the notorious slave ships of the same era, which made similar voyages from Africa.

No such damning comparisons were ever associated with Georgia's colonists, however, largely because of the special care they received from the Trustees who founded it. Nevertheless, many medical problems which afflicted the colonists can be linked directly to the difficulties encountered on their trans-Atlantic voyages. Even under the best management, immigrant ships were at times loaded far beyond recommended capacities and were consequently often cramped and unsanitary, with inadequate diets of salt meat and sea biscuit. During the 2 to 3 months at sea, the stormy Atlantic frequently forced the passengers below deck for long periods of time. There, scores of frightened colonists remained huddled together, listening to crying children, the moans of the sick and dying, and the discordant cacophony of straining timbers and rigging. Closely packed bodies raised temperatures in dimly lit holds to levels scarcely bearable, leaving the air thick with the stench of sweat, feces — both human and animal — decaying food, candle smoke, and vomit.[1]

Scurvy, beriberi, typhoid fever, and dysentery were the most common illnesses. Yellow fever and smallpox might occasionally decimate both passengers and crews, but for the most part they were not imminent dangers. While scurvy could easily be identified and prevented, typhus, typhoid, and dysentery often proved deadly on a crowded ship.[2]

The Trustees of the Georgia colony tried to overcome these hazards by planning every aspect of their voyages in detail. This included a determined effort to insure adequate diets and medical care during both the Atlantic crossing and the early stages of settlement. Theoretically, persons who were ill were excluded from the voyage. In fact, however, many of those accepted were in deplorable health, especially the children, who were often in varying states of semistarvation.[3] Ironically, the Trustees also rejected some prospective colonists who were skilled and in excellent health because they were "able to earn their bread in England. . . ."[4] Nevertheless, the Trustees felt confident that a proper diet and adequate medical care would restore everyone's health once at sea.

While immigrant ships sailing to Georgia varied in size and condition, the Trustees saw that those under their authority were adapted for passengers much like the *Anne*, the first of many ships sent to Georgia by the Trustees, and one of the three commanded by James Oglethorpe (Figure 1). The *Anne* was strong and tight, with a passenger capacity of about 100 —

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Figure 1 — James Oglethorpe, who commanded the colonial ship, *Anne*, was exemplary for his compassion for and fairness toward the passengers.



Figure 2 — The Reverend John Martin Bolzius accompanied the Salzburger Community in their Atlantic crossing. He was a leader in that community until his death in 1765.

yet she sailed with 130 persons aboard on November 6, 1732. Although space was limited, a cradle fitted to a bulkhead and enclosed with a canvas curtain provided each family with a place to sleep.[5]

As time at sea increased, so did the danger from nutritional diseases, particularly scurvy. Experienced seamen knew that eating certain vegetables minimized the danger of disease, and for this reason, easily preserved onions, cabbages, turnips, and carrots were carried on the *Anne*.[6] She also carried 10 tons of beer, a major source of nutrients.[7]

The Trustees carefully instructed the ship's captain in procedures designed to insure adequate diets and sanitary living quarters. Every 8th day, each cradle was to be cleansed with vinegar. William Cox, the surgeon on the *Anne*, was to make daily visits to every family and then report to Oglethorpe. Passengers were to be encouraged to occupy the upper deck whenever weather permitted, and bedding was to be aired regularly.

Although for each Trustee-sponsored voyage instructions for health and safety were explicit, responsibility for their implementation rested solely on the captain. Passengers received the best treatment on the three voyages headed by Oglethorpe, who was sincerely interested in the health of each passenger. He ate the same rations as the colonists, gave up his cabin to women in labor, and saw that available fresh fruit and fish were evenly distributed.[9] Such concern endeared him to passengers, boosted their morale, and encouraged their greater endurance.

Unfortunately, Oglethorpe's concern was not shared by all ship commanders, and passengers often fared badly. After a 10-week voyage in 1735, Mrs. Elizabeth Bland reported that she and the other voyagers had been victims of a leaking ship, an unpleasant captain, and a larcenous crew. Unable to eat any of the ship's stores except the biscuits and water, she landed in Charleston too weakened by dysentery to continue her journey to Georgia.[10]

The experience of the Salzburgers illustrates some of the worse conditions encountered by Georgia colonists. A pious, frugal, hardworking people, with a strong sense of community, they were ideally suited for the venture they embarked on. To flee religious persecution, they trudged across Europe carrying a few belongings on their backs and in push carts. When they arrived in England, however, many were too weak or ill to be accepted for the colony. While only the strongest were accepted, even they were severely weakened by hardships already endured.[11]

Preparations for conveying the Salzburgers to Georgia were much the same as for the English. Vessels chosen for the voyage were refitted for passengers, vegetables of various kinds were included among the ship's stores, instructions were issued to the captain to insure proper treatment of the passengers, and a German apothecary, Andreas Zwiffler, sailed with the first group to care for the sick.[12]

Even as the first boatload of Germans prepared to sail in 1733 on the *Purrysburg*, it became evident



Figure 3 — A mid-18th century view of the Georgia and South Carolina coastline, the destination of many early colonists.

that the trials of the Salzburgers had not ended. Complaints regarding the conduct of the captain, a man named Fry, reached the Trustees while the ship was still in port. Captain Thomas Coram, a Trustee representative, reminded Fry of his instructions, and conditions on the ship improved for a time. But Coram's influence ended when the *Purrysburg* sailed, and ignorance of the English language and customs made the Salzburgers easy prey for the unscrupulous and the dishonest.

Once at sea, Fry limited food rations to what one passenger described as "tough and indigestable meat." When the Germans requested cereals, soups, butter, and cheese, they were told that those items were packed away and could not be reached.

A short time later, the food ration was cut to one meal a day, consisting of small amounts of meat, a little soup or three to four turnips, a quart of beer, and 2 pints of water. What the Trustees had intended as a day's ration for one person was divided among five passengers. The situation grew even more serious when scabies developed in several children.

Weak, sick, and crowded into the hold with little food, the Salzburgers found themselves completely at the mercy of the ship's company. Although they were given a little beer to drink, the water was foul and had to be laced with wine or brandy. The only wine or brandy available had to be purchased from the crew, probably from supplies originally intended for the colonists. The two minister-leaders of the group, John Martin Bolzius (Figure 2) and Israel Gronau, were forced to purchase additional food and wine with their meager salaries. As days turned to weeks, the suffering grew more intense. Bolzius and Gronau insisted that the people be given adequate food, but Fry put them off with claims that the Trustees forbade the opening of supplies before the ship had reached Georgia. Finally, hunger and disease drove some passengers to the brink of mutiny, and Fry maintained control only with threats of beatings and death. He actually caned one outspoken colonist.[13]

After 3 horrifying months at sea, a weak, sick group of men and women stumbled ashore at Charleston (Figure 3) and embarked for their final journey to Georgia where they would begin the difficult period of adjustment in a strange, often hostile environment.

Few people actually starved to death while crossing the Atlantic. But the ever present nutritional diseases weakened the body and stripped it of its normal defenses against infectious diseases. Typhus, dysentery, typhoid, and various pulmonary afflictions were the most common.

For Georgia's colonists, the worst such outbreak occurred in 1741 aboard a ship carrying Swiss emigrants. Known only as a "malignant fever," the outbreak was probably either typhoid or typhus. During the early days of Georgia's colonization, there were no procedures established in Savannah to control contagious diseases, and medicines and physicians were in short supply. Consequently, Salzburger women, who could communicate with the German-speaking Swiss, went on board to tend the sick. They, in turn, transmitted the fever to their own families ashore, who spread the disease throughout the small settlement. The disease was less malignant ashore than on board the ship; however, mortality rates for 1741 and 1742 were higher than for any years since the first year of colonization (1733-1734), including, of course, the Swiss who had died just off Georgia's shore.[14]

Obviously, Atlantic crossings were hazardous undertakings, but for most colonists the real impact of the voyage was not felt until after their arrival, during their acclimation, or "seasoning," the period when new colonists adjusted to the unfamiliar environment. It was during this period, which usually lasted 2 years, that the colonists suffered the highest rates of mortality and incapacity. Approximately 15



Figure 4 — Mid-18th century emigrants in Georgia faced an untamed and often hostile environment.

to 20% of the immigrant population would die within 2 years after their arrival. During the important planting and harvesting season, 20 to 40% of the population would be incapacitated with various illnesses.

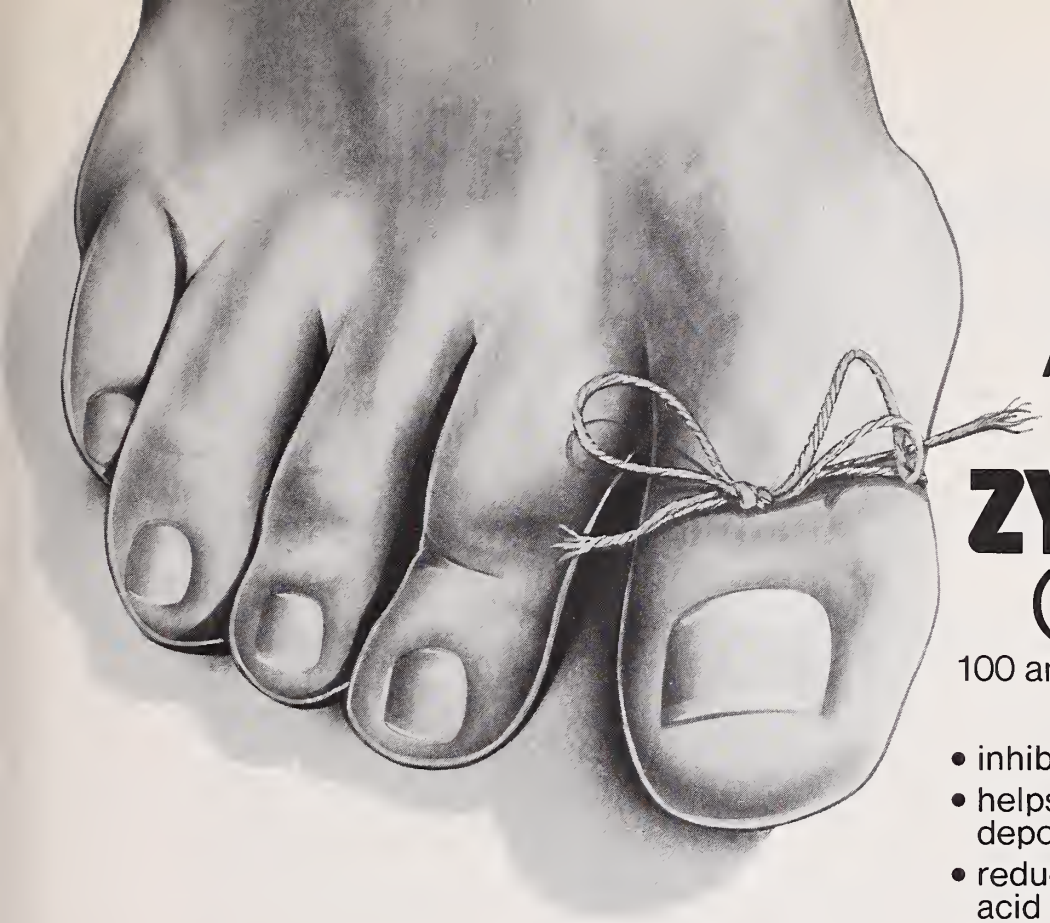
A number of other factors contributed to these heavy losses during this period of acclimation. The colonists' diets, nearly always limited to a grain porridge and salt meat, lacked many essential nutrients, and ignorance prevented them from making use of natural foods. Furthermore, because these Europeans were often products of large, urban areas and small, craft-oriented villages, they were not initially suited to their new farming responsibilities. Also, many lacked experience in basic skills necessary to build permanent shelters.

To a degree, Georgia's medical environment resulted from the unique visions of her founders. The London-based Board of Trustees, who rigidly governed Georgia from 1733 to 1753, did not encourage flexibility and innovation in the colony. Their plans regarding land ownership and agriculture and their ban on slavery forced Georgia into an unnatural state of isolation. Yet the deaths which took so many Georgia colonists in the first few years of settlement cannot be blamed on the Trustees alone. For the most part, these early deaths clearly resulted from the weakened conditions of the new colonists.

Probably such losses were inevitable. They served the cruel but probably useful purpose of weeding out the weak and unfit. Certainly no North American colonial venture possessed the degree of planning and forethought that one saw in the Georgia enterprise. Yet, despite the dedicated efforts of Oglethorpe and the Board of Trustees, death and incapacity remained a critical problem for the new colony. Even with the best motives and the most thorough planning, early colonists could not escape the handicaps imposed on them by the lack of existing technology. The winds did not obey the Trustees, and the sea had its own timetable. The voyage, then, remained an element of risk, often beyond the control of man. That element served to eliminate the weak and sickly from the pioneer population. Therefore, only the hardiest colonists were left to face the severest test of all — taming a virgin and often hostile continent (Figure 4).

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A reminder

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(allopurinol)

100 and 300 mg scored Tablets

- inhibits uric acid formation
- helps prevent urate crystal depositions in synovia
- reduces risk of uric acid lithiasis

INDICATIONS AND USE: This is not an innocuous drug and strict attention should be given to the indications for its use. Pending further investigation, its use in other hyperuricemic states is not indicated at this time.

Zyloprim® (allopurinol) is intended for:

1. treatment of gout, either primary, or secondary to the hyperuricemia associated with blood dyscrasias and their therapy;
2. treatment of primary or secondary uric acid nephropathy, with or without accompanying symptoms of gout;
3. treatment of patients with recurrent uric acid stone formation;
4. prophylactic treatment to prevent tissue urate deposition, renal calculi, or uric acid nephropathy in patients with leukemias, lymphomas and malignancies who are receiving cancer chemotherapy with its resultant elevating effect on serum uric acid levels.

CONTRAINDICATIONS: Use in children with the exception of those with hyperuricemia secondary to malignancy. The drug should not be employed in nursing mothers.

Patients who have developed a severe reaction to Zyloprim should not be restarted on the drug.

WARNINGS: ZYLOPRIM SHOULD BE DISCONTINUED AT THE FIRST APPEARANCE OF SKIN RASH OR ANY SIGN OF ADVERSE REACTION. In some instances a skin rash may be followed by more severe hypersensitivity reactions such as exfoliative, urticarial and purpuric lesions as well as Stevens-Johnson syndrome (erythema multiforme) and very rarely a generalized vasculitis which may lead to irreversible hepatotoxicity and death.

A few cases of reversible clinical hepatotoxicity have been noted and in some patients asymptomatic rises in serum alkaline phosphatase or serum transaminase have been observed. Accordingly, periodic liver function tests should be performed during the early stages of therapy, particularly in patients with pre-existing liver disease.

Patients should be alerted to the need for due precautions when engaging in activities where alertness is mandatory.

Nevertheless, iron salts should not be given simultaneously with Zyloprim. This drug should not be administered to immediate relatives of patients with idiopathic hemochromatosis.

In patients receiving Purinethol® (mercaptopurine) or Imuran® (azathioprine), the concomitant administration of 300-600 mg of Zyloprim per day will require a reduction in dose to approximately one-third to one-fourth of the usual dose of mercaptopurine or azathioprine. Subsequent adjustment of doses of Purinethol or Imuran should be made on the basis of therapeutic response and any toxic effects.

Usage in Pregnancy and Women of Childbearing Age: Zyloprim® (allopurinol) should be used in pregnant women or women of childbearing age only if the potential benefits to the patient are weighed against the possible risk to the fetus.

PRECAUTIONS: Some investigators have reported an increase in acute attacks of gout during the early stages of allopurinol administration, even when normal or subnormal serum uric acid levels have been attained.

It has been reported that allopurinol prolongs the half-life of the anticoagulant, dicumarol. This interaction should be kept in mind when allopurinol is given to patients already on anticoagulant therapy, and the coagulation time should be reassessed.

A fluid intake sufficient to yield a daily urinary output of at least 2 liters and the maintenance of a neutral or, preferably, slightly alkaline urine are desirable to (1) avoid the theoretic possibility of formation of xanthine calculi under the influence of Zyloprim therapy and (2) help prevent renal precipitation of urates in patients receiving concomitant uricosuric agents.

Patients with impaired renal function require less drug and should be carefully observed during the early stages of Zyloprim administration and the drug withdrawn if increased abnormalities in renal function appear.

In patients with severely impaired renal function, or decreased urate clearance, the half-life of oxipurinol in the plasma is greatly prolonged. Therefore, a dose of 100 mg per day or 300 mg twice a week, or perhaps less, may be sufficient to maintain adequate xanthine oxidase inhibition to reduce serum urate levels. Such patients should be treated with the lowest effective dose, in order to minimize side effects.

Mild reticulocytosis has appeared in some patients.

As with all new agents, periodic determination of liver and kidney function and complete blood counts should be performed especially during the first few months of therapy.

ADVERSE REACTIONS:

Dermatologic: Because in some instances skin rash has been followed by severe hypersensitivity reactions, it is recommended that therapy be discontinued at the first sign of rash or other adverse reaction (see WARNINGS). Skin rash, usually maculopapular, is the adverse reaction most commonly reported.
Exfoliative, urticarial and purpuric lesions, Stevens-Johnson syndrome (erythema multiforme) and toxic epidermal necrolysis have also been reported.
A few cases of alopecia with and without accompanying dermatitis have been reported.
In some patients with a rash, restarting Zyloprim (allopurinol) therapy at lower doses has been accomplished without untoward incident.

Gastrointestinal: Nausea, vomiting, diarrhea, and intermittent abdominal pain have been reported.

Vascular: There have been rare instances of a generalized hypersensitivity vasculitis or necrotizing angiitis which have led to irreversible hepatotoxicity and death.

Hematopoietic: Agranulocytosis, anemia, aplastic anemia, bone marrow depression, leukopenia, pancytopenia and thrombocytopenia have been reported in patients, most of whom received concomitant drugs with potential for causing these reactions. Zyloprim® (allopurinol) has been neither implicated nor excluded as a cause of these reactions.

Neurologic: There have been a few reports of peripheral neuritis occurring while patients were taking Zyloprim. Drowsiness has also been reported in a few patients.

Ophthalmic: There have been a few reports of cataracts found in patients receiving Zyloprim. It is not known if the cataracts predated the Zyloprim therapy. "Toxic" cataracts were reported in one patient who also received an anti-inflammatory agent; again, the time of onset is unknown. In a group of patients followed by Gutman and Yü for up to five years on Zyloprim therapy, no evidence of ophthalmologic effect attributable to Zyloprim was reported.

Drug Idiosyncrasy: Symptoms suggestive of drug idiosyncrasy have been reported in a few patients. This was characterized by fever, chills, leukopenia or leukocytosis, eosinophilia, arthralgias, skin rash, pruritus, nausea and vomiting.

OVERDOSAGE: Massive overdosing, or acute poisoning, by Zyloprim has not been reported.

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J. W. Chambers — The Complete Physician

THE DEATH of Dr. J. W. Chambers of LaGrange on July 11, 1979, represents a major loss to the members of the Medical Association of Georgia (MAG). His contributions to organized medicine, ranging from the county society level to the American Medical Association (AMA) continued from 1941 until the day of his death. These contributions are too numerous to mention in their entirety. A partial list would include his serving as a member of the Council from 1949 through 1958, chairman of this body in 1956 and 1957, chairman of the committee for drafting the Constitution and Bylaws in 1955-56, and president of the Fourth District Medical Society from 1956 to 1958. He served as a member of the MAG Finance Committee for 1 year, on the Committee for Reorganization of the Association for 3 years, and as chairman of the Health Planning Committee for 3 years.

Dr. Chambers began serving on the national level in 1958 as an Alternate Delegate to the AMA. He became a Delegate to the AMA in 1960 and continued to serve with distinction until 1975.

As would be expected of a man of such motivation and integrity, his professional qualifications and reputation in his chosen specialty of internal medicine were impeccable. He was a Diplomate of the American Board of Internal Medicine.

Those of us who knew him well are grieved at his passing but feel enriched for the privilege of having worked with a man of such proportions.

Edgar Woody Jr., M.D.

Drinking and Pregnancy — A Hazardous Combination

"IF YOU DRIVE, don't drink" has long been an aphorism universally understood by rational individuals. In this issue of the *Journal,* we are presenting two papers whose findings and conclusions point up an equally clear mandate: If you drink a significant amount of ethanol, don't conceive and subject the fetus to the documented toxic effects of alcohol.

If you drink a significant amount of ethanol, don't conceive.

In our contemporary society, the easy availability and high social acceptability of alcohol consumption among all economic and intellectual levels would appear to be the norm. As a result, alcohol has correctly been recognized as our most widespread and universal drug problem. Our advertising media have consistently barraged us with the concept that wine, beer, and whiskey are integral elements of the "good life."

. . . We as physicians have a clear mandate to warn our patients of these very real hazards during pregnancy.

In the past, many of us as physicians have been permissive in advising our patients regarding the physiologic implications of "alcohol in moderation." In the light of these recently observed irrefutable alterations in the fetus among those mothers whose alcohol consumption is significant, all physicians, and especially those of us in the obstetrical field, have a clear mandate and solemn obligation to warn our patients in the childbearing age group of these very real hazards. The ball is clearly in our court.

Edgar Woody Jr., M.D.

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Just a little extra effort from medical families and from all of the state and county societies would do much to proclaim that confidence in health care's future.

Let's all make that little extra effort.

Steve V. Seekins, Director
Office of Public Relations
American Medical Association



Sometimes give your services for nothing . . . and if there be an opportunity of serving one who is a stranger in financial straits, give full assistance to all such. For where there is love of man, there is also love of the art.

Hippocrates, *Precepts,* Sect. VI

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Frank Finnerty, M.D., Washington, D.C.

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John Raisley Coope, M.D., MRCGP, Macclesfield, England

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John Rogers, M.D., vs. Medical Association of Georgia, The Composite State Board of Medical Examiners, and George D. Busbee, Governor of the State of Georgia vs. Georgia State Medical Association

ROBERT CONNELLY, *Atlanta**

Introduction

In February, 1978, Dr. John D. Rogers instituted a civil lawsuit against the Medical Association of Georgia (MAG), The Composite State Board of Medical Examiners, and Governor George D. Busbee. In this suit, Dr. Rogers, who is not a member of the MAG, challenged the constitutionality of the Georgia law which provides for the manner of appointments to The Composite State Board of Medical Examiners. The trial court upheld the constitutionality of this statute, and Dr. Rogers appealed the case to the Supreme Court of Georgia. The Supreme Court heard oral argument in the case on July 10, 1979, and a decision from that Court is expected in the next few months.

The Facts

In 1975, the Georgia legislature amended Ga. Code Ann. §84-903, which prescribes the means by which members of The Composite State Board of Medical Examiners are appointed. The Board, which regulates many significant aspects of the practice of medicine in Georgia, is composed of 12 physicians, 10 of whom must be duly licensed M.D.s, and two of whom must be duly licensed doctors of osteopathy. With respect to the M.D.s on the Board, one Georgia physician is selected from each of the state's 10 congressional districts. The amendment to the statute provides that the Governor must make his appointments to the Board from a list of not less than three nor more than five qualified candidates submitted to him by the MAG. Once the Governor arrives at his choice, that individual's appointment must be confirmed by the Georgia Senate. The amendment to the statute became effective on January 1, 1975.

Dr. Rogers contends that the statute is unconstitutional because it gives the MAG powers which are inherently those of the Governor. That is, Dr. Rogers has argued that the statute has permitted the MAG to "capture" the Board by nominating only members of the MAG to the Governor. While the statute does not require that nominees be members of the MAG, until recently, all nominees submitted to the Governor were members of that Association. In addition to arguing that the statute gives MAG certain powers which belong to the Governor, Dr. Rogers has also stated that he has been denied rights secured to him by the equal protection and due process clauses of the Georgia Constitution and the Fourteenth Amendment to the United States Constitution as a result of the operation of the statute.

* Prepared at the request of the Medical Association of Georgia. Mr. Connelly is an associate in the firm of Powell, Goldstein, Frazer, & Murphy, general counsel to the Association, 1100 C & S National Bank Building, Atlanta, GA 30303.

At a late stage in the litigation, after the case had been pending for nearly 11 months, the Georgia State Medical Association requested the trial court to permit it to become involved in the litigation so that it could also challenge the constitutionality of the statute. The Georgia State Medical Association, which is an organization composed of most of the 135 licensed black physicians in Georgia, has challenged the statute on several of the same grounds Dr. Rogers has, and also contends that the statute has resulted in invidious discrimination based on race. The Georgia State Medical Association has made this contention notwithstanding the fact that 50 of its members are also members of the MAG and notwithstanding the fact that a black physician was a member of the Board for the fifth congressional district from 1974 through 1978 and another black doctor has been nominated for this position. The trial court rejected the arguments of the Georgia State Medical Association and refused to permit it to intervene in the main case. The Georgia State Medical Association, which is represented by the same attorneys as Dr. Rogers, has appealed this order of the trial court, and oral argument was heard on this appeal at the same time as on Dr. Rogers' appeal.

The Arguments

As indicated before, Dr. Rogers' arguments are three-fold. First, he submits that the statute in question results in an unconstitutional usurpation of the Governor's executive powers of appointment and an impermissible delegation of these powers to a private organization. Dr. Rogers has relied heavily on two cases decided in different states. In both of those cases, one decided by the Supreme Court of Pennsylvania[1] and one by the Supreme Court of Washington,[2] statutes similar to Ga. Code Ann. §84-903 were declared unconstitutional on the grounds that the legislature cannot divest governors of their totally discretionary powers of appointment to certain regulatory boards. While Dr. Rogers has relied on two non-Georgia cases, there are cases from a number of other jurisdictions in which the constitutionality of statutes like Ga. Code Ann. §84-903 has been upheld.[3] No Georgia appellate court has ever ruled on precisely the same issue which Dr. Rogers has raised; however, two cases have been decided by the courts of this state which provide some support for the position of the MAG, the Board, and the Governor.[4]

The second argument of Dr. Rogers is that he has been denied due process of law by virtue of the operation of the statute. In this connection, Dr. Rogers has submitted that since he is not a member of the MAG and since, until recently, only MAG members were nominated, he has been deprived of his right to be considered for and appointed to the Board. In opposition to this argument, the MAG, the Board, and the Governor have pointed out that there is no evidence that Dr. Rogers ever wanted to be appointed to the Board or that he ever expressed interest in such an appointment. Moreover, there is no evidence that Dr. Rogers has ever been considered by the MAG for nomination and rejected because he is not a member of MAG or for any other reason. In addition, the MAG has stated that even assuming the accuracy of Dr. Rogers' contentions, his contingent interest in being nominated for Board membership is not a constitutionally-protected property right and, therefore, not within the purview of the due process clause.

Finally, Dr. Rogers has stated that he has been denied equal protection of the laws by the statute. His argument in this regard is that the statute creates two classes of Georgia physicians who are treated in different ways — members of the MAG, who are eligible for nomination to the Board, and non-members of the MAG, who are not eligible. He argues further that this discrimination between classes of doctors in Georgia is not rationally related to any legitimate goal and should be deemed violative of the equal protection clause. In opposition to these arguments, the MAG has stated that the statute at issue does not effect such a discrimination, inasmuch as the statute does not require nor does the MAG have any rule that nominees to the Board must be members of the Association. The MAG also argues that, even assuming the statute does result in the discrimination alleged by Dr. Rogers, it is rationally related to the legitimate state goal of insuring that qualified

and dedicated individuals are appointed to the Board. In this regard, the MAG has relied heavily on a recent decision by the federal appellate court with jurisdiction over Georgia in which a Mississippi statute, nearly identical to Ga. Code Ann. §84-903, was held not to have violated the equal protection clauses of the state and federal constitutions.[5]

The MAG, the Board, and the Governor have also argued that Dr. Rogers has no right to be in court, because he has not shown that he has suffered any harm as a result of the statute or its application. In short, it is argued that Dr. Rogers lacks standing to challenge the constitutionality of the statute, since he has never demonstrated that he wanted to be appointed to the Board or that the MAG failed or refused to nominate him.

The Georgia State Medical Association has made the same arguments as Dr. Rogers with regard to the executive powers of appointment and due process. Its equal protection argument differs from that of Dr. Rogers in that the Georgia State Medical Association contends the statute results in invidious discrimination on the basis of race. The MAG has stated that the statute and its implementation do not discriminate on a racial basis because approximately 35 percent of the black physicians in Georgia belong to the MAG, and because blacks have been appointed to and nominated for the Board. The MAG, the Board, and the Governor have also opposed the addition of the Georgia State Medical Association to the case on the grounds that its application to intervene was not timely and would have interjected into the litigation new issues which would have resulted in delay and prejudice.

Ramifications

In the event the Supreme Court of Georgia accepts one or more of Dr. Rogers' arguments, the MAG would no longer possess the power to make nominations to the Governor for Board membership. Depending upon the scope and details of such a ruling, it is possible the Governor would be left to make appointments to the Board on his own without any mandatory input from a professional association or group. In addition, such a ruling could well call into question the constitutionality of other Georgia statutes which provide for similar means of nomination and appointment to boards which govern professions and occupations in Georgia.

Notes

1. *Heatherington v. McHale,* 329 A.2d 250 (Pa. 1974)

2. *United Chiropractors of Washington, Inc. v. State of Washington,* 578 P.2d 38 (Wash. 1978)

3. *See Seidenberg v. New Mexico Board of Examiners,* 80 N.M. 135, 452 P.2d 468 (N.M. 1969); *Lanza v. Wagner,* 11 N.Y. 2d 317, 183 N.E. 2d 670 (1962); *Marks v. Frantz,* 298 P.2d 316 (Kan. 1956); *Floyd v. Thornton,* 68 S.E.2d 334 (S.C. 1951); *Elrod v. Willis,* 305 Ky. 225, 203 S.W.2d 18 (1947); *Bradley v. Board of Zoning Adjustment,* 255 Mass. 160, 150 N.E. 892 (1926); *Ex parte Lucas,* 61 S.W. 218 (1901)

4. *Baranan v. State Board of Nursing Home Administrators,* 143 Ga. App. 605 (1977); *General GMC Trucks v. General Motors Corporation,* 239 Ga. 373 (1977)

5. *Finch v. Mississippi State Medical Association, Inc.,* Case No. 78-2138 (5th Cir., decided May 1, 1979)

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A Statement on Automated Blood Pressure Machines of the Coin-Operated Type

(With or Without Coin Activation)

I. The American Heart Association (AHA) does not endorse commercial products or the product of any single manufacturer whether directly, indirectly, or by implication.

II. The AHA has no regulatory powers and cannot be responsible for insuring the accuracy of automated blood pressure machines of the coin-operated type or for providing for their proper use.

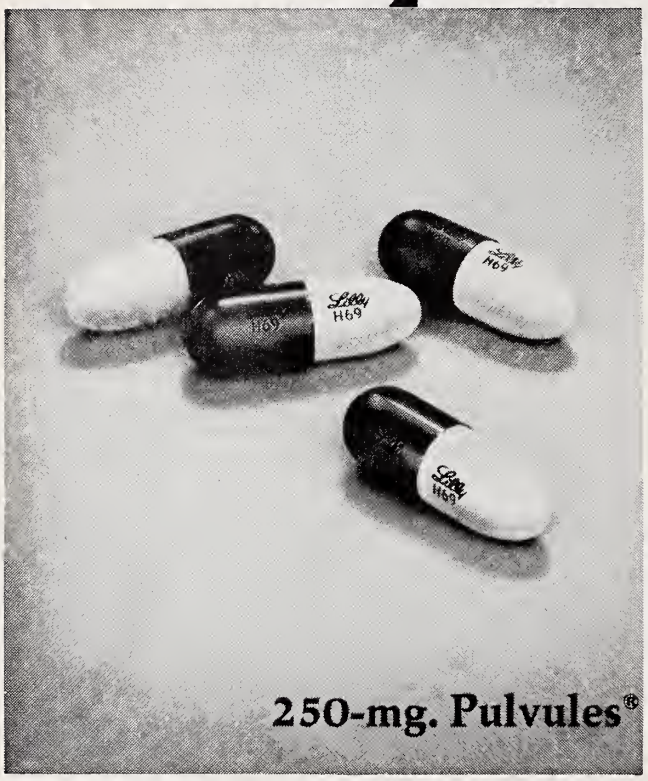
III. The AHA, however, recognizes the widespread interest in automated blood pressure machines of the coin-operated type and further notes their widespread location in public places. It is the Association's position that there would be nothing inherently wrong in the use of such machines provided that:
 A. They were accurate and remained so over long periods of time;
 B. They provided useful and correct information to the consumer;
 C. The consumer were counseled about the meaning of the reading and what should be done about it.

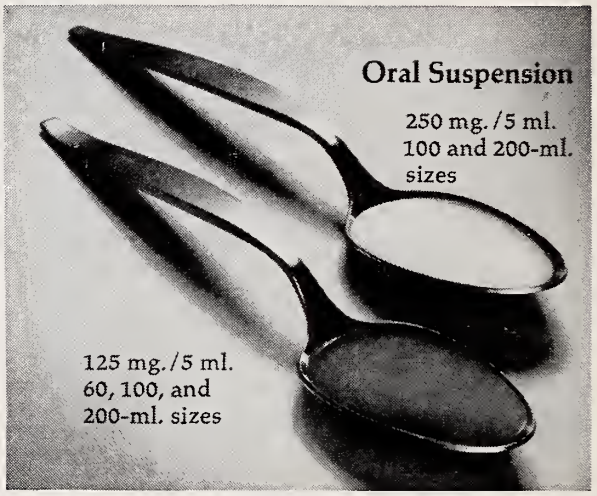
IV. The AHA does not recommend the public use of automated blood pressure machines of the coin-operated type. The Association has major concerns about the reliability, durability, and maintenance, as well as the possibility of unannounced and unknown modifications of these machines. Our recommendation is based on the following considerations:
 A. Any public blood pressure screening program should provide for adequate referral and proper counseling. These features are currently inadequate or nonexistent at the site of the coin-operated machines. The conditions and locations under which these blood pressure determinations are made are likely to produce readings which make interpretation either difficult or impossible.
 B. Data presently available are insufficient to establish the precision of these devices. An imprecise blood pressure reading could cause unnecessary anxiety or unwarrented complacency for the user.

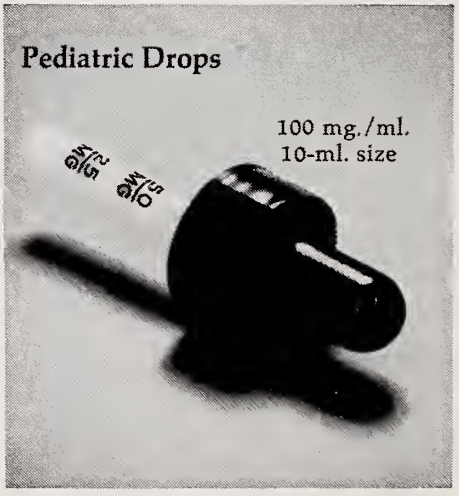
(As approved by the Steering Committee for Medical and Community Program, May 4, 1979, and the Board of Directors, June 9, 1979.)

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Stress and Cancer

HUGO J. ZEE, M.D., *Columbus**

TO THE INDIVIDUAL, the idea that he may be responsible for everything in his life, including his illness, is threatening in many ways. Taken seriously, this notion would necessitate self-examination, with consequent anxiety, which may be just what the illness has been designed to avoid. It may threaten a variety of other goals for which illness has been enlisted. And it undermines the role of the patient as innocent victim, a role which may be gratifying in itself, as well as forcing the secondary gain of care and responsibility from others.

There generally has been too much neglect of the responsibility individuals have in their lives — which in part has accounted for the popularity of the Human Potential movement which swept across the country in the 1960's and 1970's as a protest against our materialistic beliefs that external forces, in the form of machines, techniques, drugs, or organizational systems, etc., can solve what are thought to be "external problems" such as illnesses.[1]

Basically, we continue the separation between mind and body, not recognizing that we are at one and the same time expressions of both and, in principle, can be changed by working with one or the other.[2] We have sorely neglected the psychologic exploration of cancer, in contrast to the large amounts of investigations that have gone on in other fields of medicine. In short, when it comes to cancer, we have paid more attention to the body than to the mind which, because of its attitude of futility, has discouraged exploration. My aim is to urge a change in the imbalance — and to stop ignoring psychologic research or treating it only as a curiosity. Nor should the aura of pessimism that usually accompanies cancer deter us from exploring possible psychic motivations, and leave the research only to the "hard sciences."

Just as death and dying have been rendered less frightening and painful, and have indeed helped people grow immensely so that they could deal with this final of all separations[3, 4] — so likewise we may discover more about the meaning of cancer and, if not halt, at least alter its course and alert us to its message.

Here are some of the major investigations that point to the merits of inquiry about psychic motivations. One study showed that the survival after the discovery of cancer was less predictable by using the pathologist's report about the tumor and that personality factors seemed more accurate in this regard.[5] This fits with a number of impressionistic reports made by those who work with cancer patients, i.e., surgeons often report that patients who did best were distinguished by being cantankerous and generally aggressive, as compared to the compliant, "good" patients who tended to succumb. As one of them put it, "they do not go gently into that good night."

Animal studies in which stress was induced (e.g., electroshock, rough handling) led to a significantly greater incidence of cancer. Significant stress has often been seen associated with people who develop cancer. On the basis of tissue-culture studies, Hans Selye[6] writes that "normal cells can pick out and destroy cancer cells.

* Dr. Zee practices psychiatry and is Director of Therapy and Education at the Bradley Center, Inc. His address is 2000 16th Ave., Columbus, GA 31901. Prepared at the request of the Georgia Division, American Cancer Society. Others wishing to contribute papers to this page are invited to send them to David B. Roberts, M.D., 2400 13th St., Columbus, GA 31906.

The cells that have this function are the very types that have been shown to be depleted during stress.'' When a psychologic intervention leading to hope replaces stress and despair, immune activity is increased, and abnormal cells decrease in number.

Most interesting is the often quoted study of LeShan[7] who noticed that cancer patients had difficult early relationships with their parents, a feeling of rejection and distance from them; in early adulthood they found important substitutes for the difficult early relationships, and when these were lost tended to develop cancer. He also found that cancer patients had a marked inability to express anger. In a longitudinal study of hundreds of medical students, Thomas and Duszynski[8] were able to discriminate cancer patients from four other diseases on the basis of the cancer patients receiving a lack of closeness in their early relationships with their parents. In this first clear-cut longitudinal study of its kind, Thomas was able to state predictably what LeShan and others said only retrospectively. Similarly, Schmale and Iker[9] were able to predict, before diagnostic biopsies, which patients had cervical cancer, on the basis of pronounced feelings of hopelessness elicited during interviews. I could quote other sources, but I think my point has been made, i.e., that cancer can be seen as an equivalent to suicide, an action also taken under sway of feelings of helplessness and hopelessness.

When . . . hope replaces stress and despair, immune activity is increased, and abnormal cells decrease in number.

Among those who have attempted psychologic techniques of influencing cancer, the Simontons[10] from Dallas, Texas, are perhaps the best known. Simonton is an oncologist-radiologist who became increasingly impressed with the psychologic side of this disease. He and his co-workers believe that psychologic stress led to depression and despair which in turn affected the immune system. They are not adverse to conventional forms of cancer therapy, which include stimulating the immune system, but believe that the major approach would be via psychologic means. They use a meditation-visualization technique along with much coaxing, clarification, and confrontation as the patients relate their visualization experiences about their cancer. It is interesting to read about the symbolic significance these visualizations have — often indicating the patient's pervasive hopelessness (poor prognostic sign) or a sense of hopelessness about conquering the malignancy.

The ability a person has in thinking in psychologic terms and allowing himself the possibility of having responsibility for his illness — or whether he is prone to ascribe the cause of his cancer to forces outside himself does make a difference in the Simonton study. These differences matter a good deal with respect to whether patients accept the recommendations for treatment, follow through on them, and benefit from them. Such differences exist even among a population of people who have identified themselves as having psychiatric difficulties by coming to see a psychiatric worker. Many more people have psychiatric disturbances but do not identify themselves in that way, often because they have little inclination to see their difficulties as internal and to think about themselves in psychologic terms. If it is true that cancer patients have unconsciously chosen their bodies as vehicles for expression for their thoughts and feelings instead of choosing words or overt behaviors, then they would be expected to be highly resistant to seeing themselves as psychiatric patients. They would be reluctant to ascribe their difficulties to motives within themselves, rather than seeing them as something visited upon them from the outside, and resistant to thinking about themselves in terms of their emotions, feelings, and motives. The experience of the Simontons and others who have worked with cancer patients corroborates this. Even allowing for the cancer patient's physical difficulties and other situational stress due to having a life-threatening illness, they are often difficult to work with from a psychologic point of view.

The Simontons report some impressive results. Of 139 "incurable cancer" patients, 58% died; about 10% showed no more evidence of the disease, and an almost equal percentage showed tumor regressions; 12% were stabilized; and about 13% showed new tumor growth. The surviving patients exceeded two times the national average for survival time after diagnosis. It is likely that these patients represent a select group — people who were motivated, psychologically minded, open for change, open to an entirely different approach. A high proportion of them were "fighters." Moreover, under the influence of having only little time available to make changes, these people were able to grow considerably in a therapeutic experience.[2] Their efforts show that a cure for cancer, though not impossible, is not a strong likelihood; that a prolongation of life could occur (in some cases the reverse happened — the "nose dive"); and that perhaps best of all a qualitative transformation would be possible in which death became more like a natural choice, not a gruesome imposition from some feared guilt, a masochistic victory to settle an imagined injustice, or a wished for magic escape. The finality of death requires that one faces up to one's failings (the companion of immortality is omnipotence — essentially an infantile fixation) and yet retain one's dignity — often referred to as making peace with one's Maker. We can then help the dying person in this effort to become more human. Dying in that sense becomes another growth phenomenon.

One study found that cancer patients have a marked inability to express anger.

It is often said that denial is a normal defense among the dying and that it should be respected and not interfered with. I wonder who prefers to call it that way — the dying person, or those who are in attendance to him. More often, I think it is likely that both sides collude in this denial.

And then, I can also imagine cynics saying that I am denying the finality of death and cancer — and that I am falling for a magic belief in the powers of the mind. But then, cynics do not create, their pessimism holds them back from the daring of experimentation. By and large, people have benefited from the quest for knowledge about the self — and in regards to cancer, too little psychodynamic searching has been done so far.

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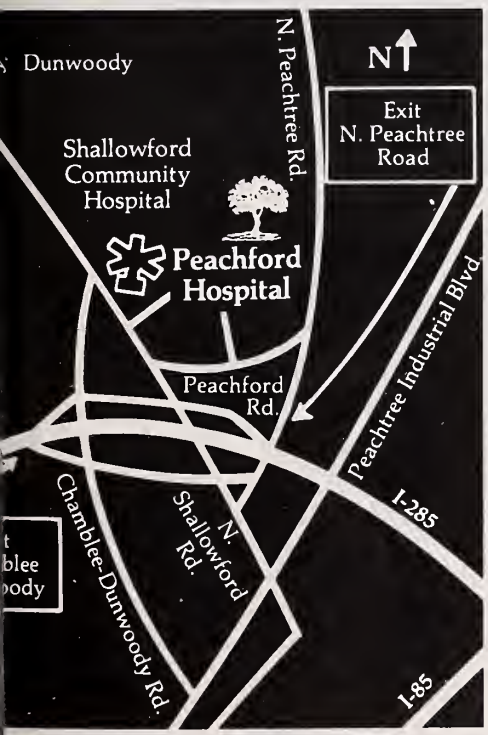
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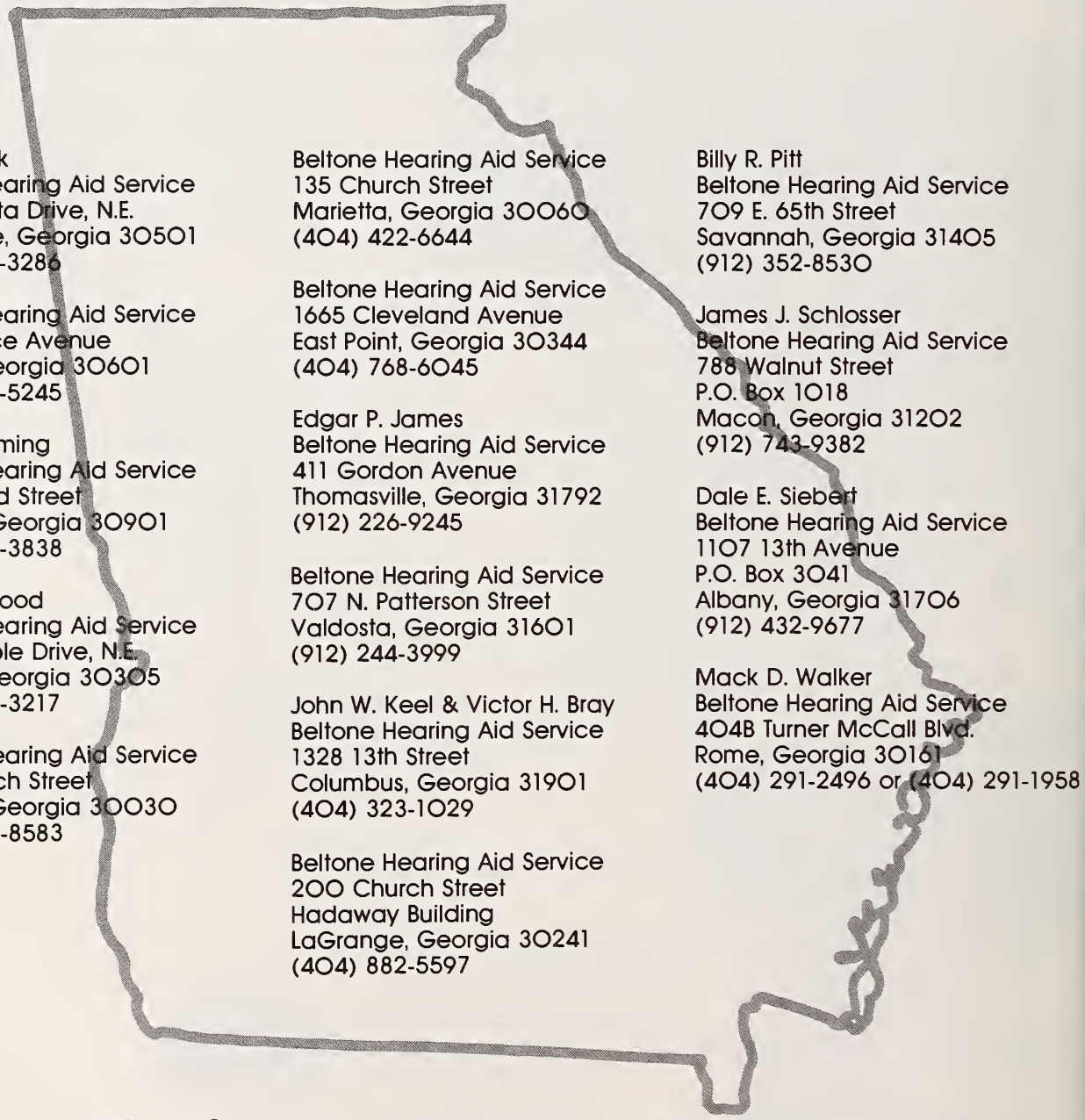


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For the past 20 years, when a patient of mine has complained about one of my fees, I have either cancelled it or reduced it to the patient's satisfaction. I do not try to please the third party carriers or government agencies — only my patients. True, I have been taken in a few times, but this is the patient's problem and not mine.

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Earnest C. Atkins, M.D.
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PERSONALS

First District

In the June 24 issue the *Savannah Morning News* honored **John Elliott, M.D.,** for his help in finding a remedy for tuberculosis.

Savannah physician, **Harvey C. Lebos, M.D.,** was recently selected as a member of the Board of Trustees of the Leukemia Society of America, Georgia Chapter.

Second District

Charles Walker, M.D., Donalsonville, has recently joined the staff at Memorial Hospital in Bainbridge as a general surgeon.

Third District

A. C. Alvarez, M.D., Columbus, was elected to Associate Fellowship in the American Academy of Pediatrics at the meeting of AAP Executive Board in Toronto, Ontario.

Columbus physicians **Robert H. Carpenter, M.D., Waverly B. Dasheill, M.D.,** and **W. David Varner, M.D.** have received recertification by the American Board of Obstetrics and Gynecology.

John H. Deaton, M.D., of Columbus, has been named a Fellow of the American College of Radiology in recognition for distinguished medical achievements. The College awarded Dr. Deaton a Certificate of Fellowship during its annual meeting and convocation in Chicago, Sept. 19.

Fifth District

David G. Campbell, M.D., assistant professor of ophthalmology at Emory University School of Medicine, was selected by Research to Prevent Blindness, Inc., as one of the most promising young investigators in ophthalmologic research in the U.S. He received the annual Robert E. McCormick Scholar award to assist him in his research in glaucoma and related diseases.

Dave M. Davis, M.D., of Atlanta, was in the first group of 23 psychiatrists in the United States to be certified by the American Board of Forensic Psychiatry, Inc., in Forensic Psychiatry. On July 19, Dr. Davis spoke at the Peachtree and Parkwood Mental Health Center on, "An Overview of Mental Health Problems." This was the first of two programs presented by the Center concerning industrial and business mental health problems.

The Medical Research Foundation at the School of Biology, Georgia Institute of Technology, has received a $225,000 grant from the National Cancer Institute of the National Institute of Health. Under the direction of **Edgar Grady, M.D.,** Riverdale, the Foundation will study the development of radioactive antibodies as a method to destroy cancerous cells.

Elna Phelan, M.D., of Atlanta, has recently been selected as a member of the Board of Trustees of the Leukemia Society of America, Georgia Chapter.

William E. Silver, M.D., of Atlanta, recently presented a paper, "Facial Contouring With the Use of Proplast Implant," at the Third International Symposium on Plastic and Reconstructive Surgery of the Head and Neck.

Sixth District

The Georgia Academy of Family Physicians has established an annual scholarship award in the name of **T. A. Sappington, M.D.,** of Thomaston.

Seventh District

Harvey N. Sacks, M.D., was recently named to Consulting Active Staff of the Paulding Memorial Hospital.

SOCIETIES

At their July meeting the **DeKalb Medical Society** heard Edgar V. Howell Jr., M.D., speak on Civil War orthopedics.

The **Muscogee County Medical Society** held a public relations workshop for medical assistants, August 16, at The Medical Center Auditorium in Columbus. Karen Zupko, Director of the Department of Practice Management of the American Medical Association, conducted the workshop. The society also held an orientation program for new physicians entering the society during the past year at the Harmony Club. The faculty consisted of local members of the society and Ms. Zupko. The local members indoctrinated the new members as to the functions of the HSA, PSRO, the work of the Board of Directors of MAG, and the structure of organized medicine.

DEATHS

Wistar Graham

Wistar Graham, M.D., of Marietta, died Friday, July 13. He was 62.

Dr. Graham had been medical director of Lockheed-Georgia Company since 1969. He retired from the Air Force in 1969 as a brigadier general. Following his graduation from the University of Georgia School of Medicine, he entered the U.S. Army Reserves. During World War II, Dr. Graham served as a flight surgeon with the 8th Air Force. He commanded hospitals at Alexandria Air Force Base, Louisiana; Shahran Air Force Base, Saudi Arabia; and Stewart Air Force Base, Tennessee. He was also hospital commander and chief of neurosurgery at Maxwell Air Force Base, Alabama.

Survivors include his wife, a daughter, and a son.

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The Splendour of Beauty;
For Yesterday is but a Dream,
And To-morrow is only a Vision,
But To-day well lived makes
Every Yesterday a Dream of Happiness,
And every To-morrow a Vision of Hope.
Look well, therefore, to this Day!
Such is the Salutation of the Dawn.

* This poem from the Sanskrit was sent to Sir William Osler by de Haviland Hall. It was inscribed by Dr. Osler in a copy of "A Way of Life," in his own library.

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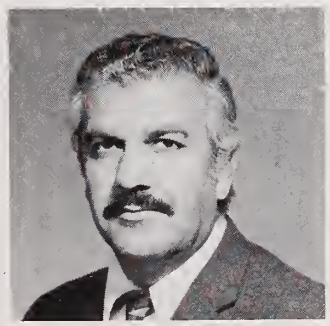
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Renovated Crawford W. Long Museum To Be Reopened September 30

The Crawford W. Long Museum, located 55 miles northeast of Atlanta (4 miles from Interstate 85) in Jefferson, Georgia, is being renovated by the Medical Association of Georgia (MAG), and is due to reopen on Sept. 30, 1979. Rededication ceremonies are slated for 2:30, and physicians and others interested are invited to attend.

This museum was first opened in 1957 by the MAG and with the assistance of grants from the state. It is now owned and operated by the City of Jefferson. The original diorama of Dr. Long's first use of ether as an anesthetic is a featured exhibit, and other exhibits offer insight into Dr. Long's life as a physician as well as the mid-nineteenth century in which he lived.

Doctor, Know This Emblem

The person who wears this pin is a member of the American Association of Medical Assistants (AAMA), Inc. To be an effective and proficient member of the allied health team, the medical assistant must keep continually informed of the constant changes in her field. The AAMA is a national, non-profit organization dedicated to that kind of professional advancement. It helps to do this by providing educational programs and seminars which meet high professional standards. There are 16 active chapters in Georgia.

For more information, contact Sandy Whitman, CMA-AC, membership chairman, Georgia State Society of the AAMA at (404) 763-3506.

(Submitted by Alvin H. Clair, M.D., Advisor to Georgia State Society, AAMA.)

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CONTRAINDICATIONS: Advanced arteriosclerosis, hyperthyroidism, known hypersensitivity, or idiosyncrasy to the sympathomimetic amines, glaucoma. Agitated states. Patients with a history of drug abuse. During or within 14 days following the administration of monoamine oxidase inhibitors, (hypertensive crises may result).

WARNINGS: If tolerance develops, the recommended dose should not be exceeded in an attempt to increase the effect; rather, the drug should be discontinued. Tenuate may impair the ability of the patient to engage in potentially hazardous activities such as operating machinery or driving a motor vehicle; the patient should therefore be cautioned accordingly. *Drug Dependence:* Tenuate has some chemical and pharmacologic similarities to the amphetamines and other related stimulant drugs that have been extensively abused. There have been reports of subjects becoming psychologically dependent on diethylpropion. The possibility of abuse should be kept in mind when evaluating the desirability of including a drug as part of a weight reduction program. Abuse of amphetamines and related drugs may be associated with varying degrees of psychologic dependence and social dysfunction which, in the case of certain drugs, may be severe. There are reports of patients who have increased the dosage to many times that recommended. Abrupt cessation following prolonged high dosage administration results in extreme fatigue and mental depression; changes are also noted on the sleep EEG. Manifestations of chronic intoxication with anorectic drugs include severe dermatoses, marked insomnia, irritability, hyperactivity, and personality changes. The most severe manifestation of chronic intoxications is psychosis, often clinically indistinguishable from schizophrenia. *Use in Pregnancy*: Although rat and human reproductive studies have not indicated adverse effects, the use of Tenuate by women who are pregnant or may become pregnant requires that the potential benefits be weighed against the potential risks. *Use in Children*: Tenuate is not recommended for use in children under 12 years of age.

PRECAUTIONS: Caution is to be exercised in prescribing Tenuate for patients with hypertension or with symptomatic cardiovascular disease, including arrhythmias. Tenuate should not be administered to patients with severe hypertension. Insulin requirements in diabetes mellitus may be altered in association with the use of Tenuate and the concomitant dietary regimen. Tenuate may decrease the hypotensive effect of guanethidine. The least amount feasible should be prescribed or dispensed at one time in order to minimize the possibility of overdosage. Reports suggest that Tenuate may increase convulsions in some epileptics. Therefore, epileptics receiving Tenuate should be carefully monitored. Titration of dose or discontinuance of Tenuate may be necessary.

ADVERSE REACTIONS: *Cardiovascular*: Palpitation, tachycardia, elevation of blood pressure, precordial pain, arrhythmia. One published report described T-wave changes in the ECG of a healthy young male after ingestion of diethylpropion hydrochloride. *Central Nervous System*: Overstimulation, nervousness, restlessness, dizziness, jitteriness, insomnia, anxiety, euphoria, depression, dysphoria, tremor, dyskinesia, mydriasis, drowsiness, malaise, headache; rarely psychotic episodes at recommended doses. In a few epileptics an increase in convulsive episodes has been reported. *Gastrointestinal*: Dryness of the mouth, unpleasant taste, nausea, vomiting, abdominal discomfort, diarrhea, constipation, other gastrointestinal disturbances. *Allergic*: Urticaria, rash, ecchymosis, erythema, *Endocrine*: Impotence, changes in libido, gynecomastia, menstrual upset. *Hematopoietic System*: Bone marrow depression, agranulocytosis, leukopenia. *Miscellaneous*: A variety of miscellaneous adverse reactions has been reported by physicians. These include complaints such as dyspnea, hair loss, muscle pain, dysuria, increased sweating, and polyuria.

DOSAGE AND ADMINISTRATION: Tenuate (diethylpropion hydrochloride): One 25 mg. tablet three times daily, one hour before meals, and in midevening if desired to overcome night hunger. Tenuate Dospan (diethylpropion hydrochloride) controlled-release: One 75 mg. tablet daily, swallowed whole, in midmorning. Tenuate is not recommended for use in children under 12 years of age.

OVERDOSAGE: Manifestations of acute overdosage include restlessness, tremor, hyperreflexia, rapid respiration, confusion, assaultiveness, hallucinations, panic states. Fatigue and depression usually follow the central stimulation. Cardiovascular effects include arrhythmias, hypertension or hypotension and circulatory collapse. Gastrointestinal symptoms include nausea, vomiting, diarrhea, and abdominal cramps. Overdose of pharmacologically similar compounds has resulted in fatal poisoning, usually terminating in convulsions and coma. Management of acute Tenuate intoxication is largely symptomatic and includes lavage and sedation with a barbiturate. Experience with hemodialysis or peritoneal dialysis is inadequate to permit recommendation in this regard. Intravenous phentolamine (Regitine®) has been suggested on pharmacologic grounds for possible acute, severe hypertension, if this complicates Tenuate overdosage.

Product Information as of April, 1976

MERRELL-NATIONAL LABORATORIES Inc.
Cayey, Puerto Rico 00633

Direct Medical Inquiries to:
MERRELL-NATIONAL LABORATORIES
Division of Richardson-Merrell Inc.
Cincinnati, Ohio 45215, U.S.A.

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References: 1. Citations available on request from Medical Research Department, MERRELL-NATIONAL LABORATORIES. Cincinnati, Ohio 45215. 2. Hoekenga, M.T., O'Dillon [Dillon], R.H., and Leyland, H.M.: A comprehensive review of diethylpropion hydrochloride. In, Central Mechanisms of Anorectic Drugs, S. Garattini and R. Samanin, Ed., New York, Raven Press, 1978, pp. 391-404.

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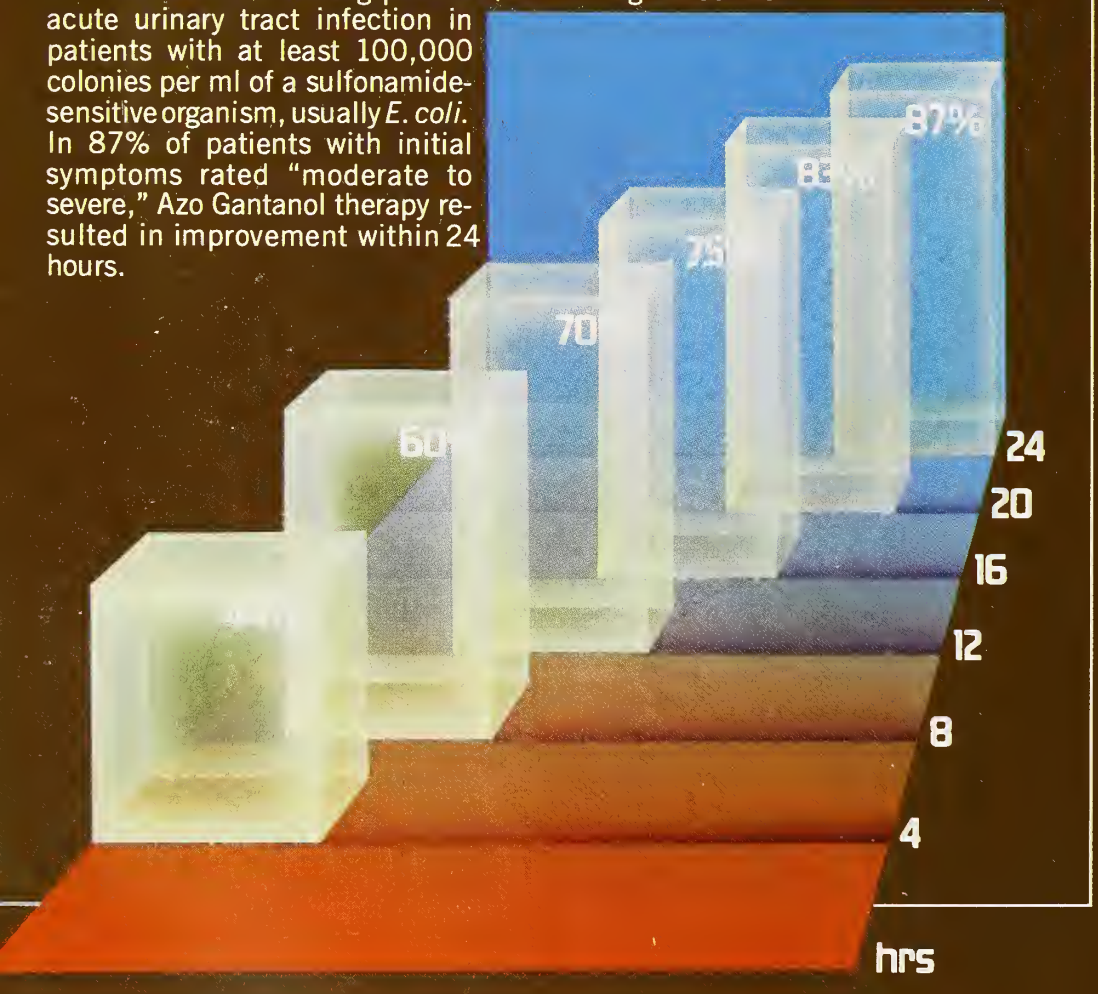
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*Data on file, Hoffmann-La Roche Inc., Nutley, New Jersey 07110.

Before prescribing, please consult complete product information, a summary of which follows:

Indications: In adults, urinary tract infections complicated by pain (primarily pyelonephritis, pyelitis and cystitis) due to susceptible organisms (usually *E. coli, Klebsiella-Aerobacter, Staphylococcus aureus, Proteus mirabilis,* and, less frequently, *Proteus vulgaris*) in the absence of obstructive uropathy or foreign bodies. **Note: Carefully coordinate *in vitro* sulfonamide sensitivity tests with bacteriologic and clinical response; aminobenzoic acid to follow-up culture media. The increasing frequency of resistant organisms limits the usefulness of antibacterials including sulfonamides.** Measure sulfonamide blood levels as variations may occur; 20 mg/100 ml should be maximum total level.

Contraindications: Children below age 12; sulfonamide hypersensitivity; pregnancy at term and during nursing period; because Azo Gantanol contains phenazopyridine hydrochloride it is contraindicated in glomerulonephritis, severe hepatitis, uremia, and pyelonephritis of pregnancy with G.I. disturbances.

Warnings: Safety during pregnancy not established. Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been reported and early clinical signs (sore throat, fever, pallor, purpura or jaundice) may indicate serious blood disorders. Frequent CBC and urinalysis with microscopic examination are recommended during sulfonamide therapy.

Precautions: Use cautiously in patients with impaired renal or hepatic function, severe allergy, bronchial asthma; in glucose-6-phosphate dehydrogenase-deficient individuals in whom dose-related hemolysis may occur. Maintain adequate fluid intake to prevent crystalluria and stone formation.

Adverse Reactions: *Blood dyscrasias* (agranulocytosis, aplastic anemia, thrombocytopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia); *allergic reactions* (erythema multiforme, skin eruptions, Stevens-Johnson syndrome, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis); *G.I. reactions* (nausea, emesis, abdominal pain, hepatitis, diarrhea, anorexia, pancreatitis and stomatitis); *CNS reactions* (headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo and insomnia); *miscellaneous reactions* (drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L. E. phenomenon). Due to certain chemical similarities with some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia. Cross-sensitivity with these agents may exist.

Dosage: Azo Gantanol is intended for the acute painful phase of urinary tract infections. *Usual adult dosage:* 2 Gm (4 tabs) initially, then 1 Gm (2 tabs) B.I.D. for up to 3 days. If pain persists, causes other than infection should be sought. After relief of pain has been obtained, continue treatment with Gantanol (sulfamethoxazole) may be considered.

NOTE: Patients should be told that the orange dye (phenazopyridine HCl) will color the urine.

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Physician's Recognition Award Recipients

LISTED BELOW *are those physicians in Georgia who have earned the AMA's Physician's Recognition Award from April through June 1979.*

The award was established in 1969 "to recognize, encourage and support physicians who participate regularly in continuing medical education and to emphasize the importance of developing more meaningful continuing medical education opportunities for physicians." A minimum of 150 credit hours of CME must be earned over a three-year period to qualify for the award. The hours may include such activities as conferences, residencies, teaching, writing, private reading, listening to cassettes, home study courses, consultation, and peer review; at least 60 of the hours, however, must be from formal CME programs sponsored or co-sponsored by organizations accredited for these activities.

We congratulate the following physicians who have distinguished themselves and their profession by their commitment to continuing education:

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Indications: Relief of anxiety and tension occurring alone or accompanying various disease states. Efficacy beyond four months not established by systematic clinical studies. Periodic reassessment of therapy recommended.

Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Warn patients that mental and/or physical abilities required for tasks such as driving or operating machinery may be impaired, as may be mental alertness in children, and that concomitant use with alcohol or CNS depressants may have an additive effect. Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported.

Usage in Pregnancy: **Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

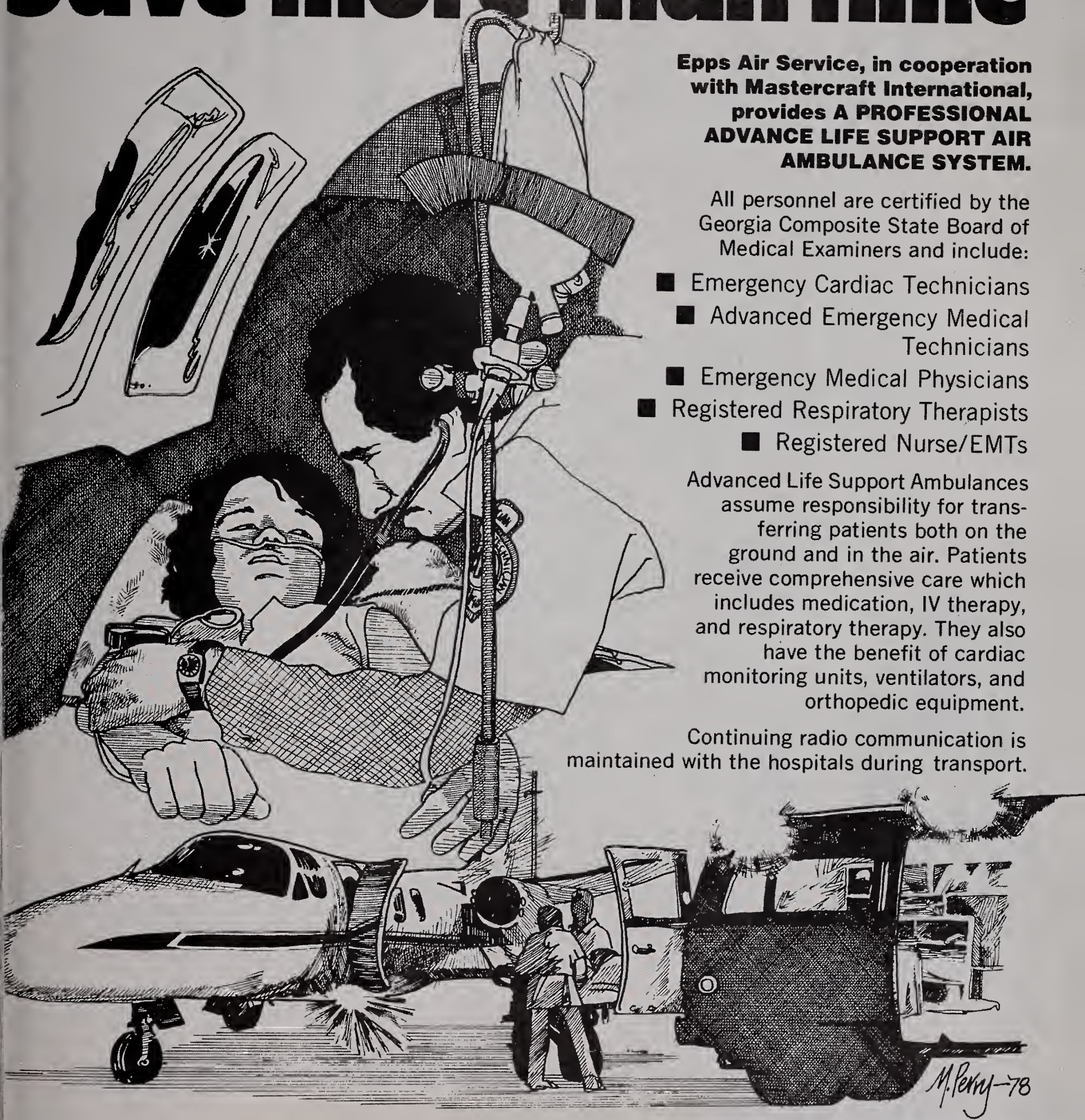
Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

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THE COVER

Some of the many facets of the MAG's activities on behalf of its membership is the subject of this month's cover story. Cover design by Richard Lyons of Richard Hieman Advertising.

For the busiest Radiologists and Physicists in the South...

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In years past you may have found it difficult to get away for the trip to our meetings in Chicago. This year it's just a trip to Atlanta. The main reason we are here is to give you an opportunity to attend our Scientific Assembly.

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If you have not already mailed the forms in your August issue of *RADIOLOGY*, call direct to RSNA Headquarters, 312/920-2684. We will do everything possible to accommodate you.

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ATLANTA, NOVEMBER 25-30, 1979
65TH SCIENTIFIC ASSEMBLY
AND ANNUAL MEETING
INCLUDING SESSIONS IN JOINT
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ATLANTA PERSPECTIVE RSNA '79

Letter to the Members of the MAG . . .

Emory Medical Student Opines on AMA Convention

Mr. James M. Moffett
Executive Director
Medical Association of Georgia
938 Peachtree Street, N.E.
Atlanta, Georgia 30309

Dear Mr. Moffett:

I wish to thank the Medical Association [of Georgia] for sponsoring my trip to the A.M.A. convention in Chicago. The experience of seeing organized medicine at work was truly an educational experience that I will remember.

I returned to Atlanta both encouraged and disappointed by what I saw at the convention. I was encouraged by the sincere concern which I believe that the physicians present have for their patients as individuals. I was encouraged by the A.M.A.'s position on Tobacco Advertising,[1] Crop Supports for Tobacco,[2] The World Health Organization,[3] voting privileges for medical students serving on A.M.A. councils and committees,[4] and the "Doctor's Draft."[5] I was also pleased to find many delegates willing to listen to my ideas and opinions on the issues addressed at the convention.

However, I was disappointed in the way that issues involving public policy and subjects requiring a knowledge of the "big picture" were resolved. Specifically, a lack of knowledge concerning our nation's economic situation and economic trends related to health seemed to be present,[6] as well as lack of knowledge concerning physician extenders[7] and international health.[8] I feel that it is time for the A.M.A. and the M.A.G. to recognize that involvement in a private medical practice does not necessarily qualify an individual as an expert in health legislation, public policy, and health economics, due to the complexity of these fields. I believe that the A.M.A.'s responsiveness to the needs of our nation's people and the A.M.A.'s credibility among health legislators and policy makers can be improved by: (1) encouraging medical schools to include courses in health economics and public policy in the medical school curriculum, (2) encouraging continuing education in health economics and public policy for physicians involved in formulating A.M.A. policy, and (3) increasing A.M.A. membership so that the A.M.A. really represents the majority of American physicians.

It is my belief that a stronger bond between medical students and practicing physicians will promote a greater understanding of social and medical issues. It is my hope that today's medical students will be able to help direct the evolution of organized medicine so that it will more accurately express the needs of the American people and more accurately represent the opinions of American physicians.

Sincerely,
Eddie Trevathan
Medical Student
Emory University School of Medicine

References

(All refer to Resolutions and Reports as listed in the Handbook of the A.M.A. House of Delegates.)

1. Resolution 99 — adopted
2. Resolution 12 — amended and adopted
3. Resolution 56 — adopted
4. Resolution 123 — adopted
5. Resolution 133 — amended and adopted
6. Reports Y, AA, F, and Resolution 138 — all adopted
7. Report F — adopted
8. AMA position on infant nutrition in third world countries — Report M.


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Assembly
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•Alumni gatherings
•Conference on medical schools
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MEDICAL MEETING CALENDAR

OCTOBER

19—*Atlanta;* **PROGRESS IN LEUKEMIA PATHOPHYSIOLOGY AND TREATMENT;** Category 1 credit; Contact: Associate Dean for CME, Emory Univ. Sch. of Med., 69 Butler St., SE, Atlanta 30303. PH: 404/588-3534.

19-20—*Atlanta;* **CONTROVERSIES IN THE MANAGEMENT OF HYPERTENSION;** Category 1 credit; Contact: Associate Dean for CME, Emory Univ. Sch. of Med., 69 Butler St., SE, Atlanta 30303. PH: 404/588-3534.

19-20—*Atlanta;* **RADIOLOGY OF THE SPINE AND NEURAL CANAL;** Category 1 credit; Contact: Associate Dean for CME, Emory Univ. Sch. of Med., 69 Butler St., SE, Atlanta 30303. PH: 404/588-3534.

24-26—*Atlanta;* **ECHOCARDIOGRAPHY WORKSHOP;** Category 1 credit; Contact: Associate Dean for CME, Emory Univ. Sch. of Med., 69 Butler St., SE, Atlanta 30303. PH: 404/588-3534.

26-27—*Pine Mountain;* **THE FAMILY PRACTICE;** Category 1 credit; Contact: Associate Dean for CME, Emory Univ. Sch. of Med., 69 Butler St., SE, Atlanta 30303. PH: 404/588-3534.

27-28—*Pine Mountain;* **PHYSICIAN RECRUITMENT CONFERENCE AND PRE-PRACTICE SEMINAR;** Contact: Joyce Butler, Medical Association of Georgia, 938 Peachtree St., NE, Atlanta 30309. PH: 404/876-7535.

27-28—*Nashville, TN;* **AMA REGIONAL CME MEETING: CARDIAC ARRHYTHMIAS; PULMONARY FUNCTION & BLOOD GASES; ACID-BASE, FLUID, & ELECTROLYTE BALANCE; BASIC CPR; INFECTIOUS DISEASES; OFFICE ORTHOPEDICS; ADVANCED CPR;** Category 1 credit; Contact: Council on Continuing Physician Education, AMA—535 N. Dearborn St., Chicago, IL 60610. PH: 312/751-6000.

NOVEMBER

3-4—*Asheville, NC;* **AMA REGIONAL CME MEETING: ELECTROCARDIOGRAPHY; DIABETES; OFFICE DERMATOLOGY; PULMONARY FUNCTION & BLOOD GASES; PRACTICE MANAGEMENT; CARDIOVASCULAR DISEASE; CHEST X-RAYS; ANTIBIOTICS; ACID-BASE, FLUID & ELECTROLYTE BALANCE;** Category 1 credit; Contact: Council on Continuing Physician Education, AMA—535 N. Dearborn St., Chicago, IL 60610. PH: 312/751-6000.

4-7—*Las Vegas, NV;* **SOUTHERN MEDICAL ASSOCIATION SCIENTIFIC ASSEMBLY;** Category 1 credit; Contact: Roy Evans, Executive Director, Southern Medical Association, 2601 Highland Ave., Birmingham, AL 35205. PH: 205/323-4400.

5-7—*Atlanta;* **GENERAL REVIEW OF PEDIATRICS;** Category 1 credit; Contact: Associate Dean for CME, Emory Univ. Sch. of Med., 69 Butler St., SE, Atlanta 30303. PH: 404/588-3534.

5-9—*Kissimmee, FL;* **10th FAMILY PRACTICE REVIEW;** Category 1 credit; Contact: Bill Rockwood, Coordinator, Box J-233, J. Hillis Miller Health Center, Office of CME, Gainesville, FL 32610. PH: 904/392-3143 or 392-3183.

9—*Johnson City, TN;* **PEDIATRICS—NEONATOLOGY;** Contact: Dr. Charles F. Johnson, Dept. of CME, East Tennessee State Univ. College of Medicine, Johnson City, TN 37601. PH: 615/929-5364.

9-10—*Chattanooga, TN;* **DIAGNOSTIC RADIOLOGY;** Contact: Dennis K. Wentz, M.D., UT Center for the Health Sciences, 62 Dunlap St., Memphis, TN 38163. PH: 901/528-5606.

9-10—*Nashville, TN;* **UPDATE IN ANESTHESIOLOGY 1979;** Contact: Vanderbilt Continuing Education, 305 Medical Arts Bldg.; Nashville, TN 37212. PH: 615/322-2716.

15-16—*Augusta;* **INSTRUCTION IN THE CLINICAL SETTING;** Category 1 credit; Contact: School of Medicine, Medical College of Georgia, Augusta, 30912.

15-18—*Atlanta;* **MAG SCIENTIFIC ASSEMBLY;** Category 1 credit; Contact: Stephen L. Daniel, Ph.D., Medical Association of Georgia, 938 Peachtree St., NE, Atlanta 30309. PH: 404/876-7535.

15-18—*Atlanta;* **ANNUAL MEETING, ACADEMY OF PSYCHOSOMATIC MEDICINE;** Contact: Tom Nelson, Executive Director, Academy of Psychosomatic Medicine, 153 W. Ohio St., Chicago, IL 60610. PH: 312/644-2623.

25-30—*Atlanta;* **MEETING, RADIOLOGICAL SOCIETY OF NORTH AMERICA;** Contact: A. Swenson, Executive Director, Ste. 1150, 1415 W. 22nd St., Oak Brook, IL 60521.

30-Dec 1—*Gainesville, FL;* **THIRD ANNUAL MEETING, MEDICAL ASPECTS OF AGING;** Category 1 credit; Contact: Bill Rockwood, Coordinator, Box J-233, J. Hillis Miller Health Center, Office of CME, Gainesville, FL 32610. PH: 904/392-3143 or 392-3183.

30-Dec 2—*Chattanooga, TN;* **BASIC CARDIOLOGY, EKGs AND THERAPY;** Contact: Dennis K. Wentz, M.D., UT Center for the Health Sciences, 62 South Dunlap St., Memphis, TN 38163. PH: 901/528-5606.

DECEMBER

5-9—*Atlanta;* **FOURTH SOUTHEASTERN CONFERENCE ON ALCOHOL AND DRUG ABUSE;** Category 1 credit; Contact: Conway Hunter, M.D., Fourth SECAD, Peachford Hospital, 2151 Peachford Road, NE, Atlanta 30338. PH: 404/455-3200.

6-7—*Atlanta;* **GLAUCOMA UPDATE: ADVANCE IN DIAGNOSIS AND TREATMENT;** Category 1 credit; Contact: Associate Dean for CME, Emory Univ. Sch. of Med., 69 Butler St., SE, Atlanta 30303. PH: 404/588-3534.

7—*Atlanta;* **FIFTH ANNUAL HOLIDAY INFECTIOUS DISEASES SEMINAR — ADVANCES 1979;** Category 1 credit; Contact: Dept. of Graduate and CME, Georgia Baptist Medical Center, 300 Boulevard, N.E., Atlanta 30312. PH: 404/659-4211, ext. 2346.

7-9—*Atlanta;* **SOUTHEAST REGIONAL CONFERENCE, INTERNATIONAL ACADEMY OF PREVENTIVE MEDICINE;** Contact; Joseph A. Nowell, Executive Director, International Academy of Preventive Medicine, 10409 Town and County Way #200, Houston, TX 77024. PH: 713/468-7851.

14-15—*Birmingham, AL;* **MKSAP: ALLERGY/IMMUNOLOGY, INFECTIOUS DISEASE, ENDOCRINOLOGY/METABOLISM, ONCOLOGY;** Contact: Jaan Kangilaski, American College of Physicians, 4200 Pine St., Philadelphia, PA 19104. PH: 215/243-1200.

16-18—*Athens;* **TREATMENT OF MENTAL HEALTH PROBLEMS OF THE AGED, UP-DATE;** Contact: Mr. Don NeSmith, Conference Coordinator, Univ. of Georgia Center for Continuing Education, Athens, GA 30602. PH: 404/542-2242.

For additional information on these and other meetings, contact MAG, Division of Education 404/876-7535.

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Brief Summary

INDICATION: Tenuate and Tenuate Dospan are indicated in the management of exogenous obesity as a short-term adjunct (a few weeks) in a regimen of weight reduction based on caloric restriction. The limited usefulness of agents of this class should be measured against possible risk factors inherent in their use such as those described below.

CONTRAINDICATIONS: Advanced arteriosclerosis, hyperthyroidism, known hypersensitivity, or idiosyncrasy to the sympathomimetic amines, glaucoma. Agitated states. Patients with a history of drug abuse. During or within 14 days following the administration of monoamine oxidase inhibitors, (hypertensive crises may result).

WARNINGS: If tolerance develops, the recommended dose should not be exceeded in an attempt to increase the effect; rather, the drug should be discontinued. Tenuate may impair the ability of the patient to engage in potentially hazardous activities such as operating machinery or driving a motor vehicle; the patient should therefore be cautioned accordingly. *Drug Dependence:* Tenuate has some chemical and pharmacologic similarities to the amphetamines and other related stimulant drugs that have been extensively abused. There have been reports of subjects becoming psychologically dependent on diethylpropion. The possibility of abuse should be kept in mind when evaluating the desirability of including a drug as part of a weight reduction program. Abuse of amphetamines and related drugs may be associated with varying degrees of psychologic dependence and social dysfunction which, in the case of certain drugs, may be severe. There are reports of patients who have increased the dosage to many times that recommended. Abrupt cessation following prolonged high dosage administration results in extreme fatigue and mental depression; changes are also noted on the sleep EEG. Manifestations of chronic intoxication with anorectic drugs include severe dermatoses, marked insomnia, irritability, hyperactivity, and personality changes. The most severe manifestation of chronic intoxications is psychosis, often clinically indistinguishable from schizophrenia. *Use in Pregnancy:* Although rat and human reproductive studies have not indicated adverse effects, the use of Tenuate by women who are pregnant or may become pregnant requires that the potential benefits be weighed against the potential risks. *Use in Children:* Tenuate is not recommended for use in children under 12 years of age.

PRECAUTIONS: Caution is to be exercised in prescribing Tenuate for patients with hypertension or with symptomatic cardiovascular disease, including arrhythmias. Tenuate should not be administered to patients with severe hypertension. Insulin requirements in diabetes mellitus may be altered in association with the use of Tenuate and the concomitant dietary regimen. Tenuate may decrease the hypotensive effect of guanethidine. The least amount feasible should be prescribed or dispensed at one time in order to minimize the possibility of overdosage. Reports suggest that Tenuate may increase convulsions in some epileptics. Therefore, epileptics receiving Tenuate should be carefully monitored. Titration of dose or discontinuance of Tenuate may be necessary.

ADVERSE REACTIONS: *Cardiovascular:* Palpitation, tachycardia, elevation of blood pressure, precordial pain, arrhythmia. One published report described T-wave changes in the ECG of a healthy young male after ingestion of diethylpropion hydrochloride. *Central Nervous System:* Overstimulation, nervousness, restlessness, dizziness, jitteriness, insomnia, anxiety, euphoria, depression, dysphoria, tremor, dyskinesia, mydriasis, drowsiness, malaise, headache; rarely psychotic episodes at recommended doses. In a few epileptics an increase in convulsive episodes has been reported. *Gastrointestinal:* Dryness of the mouth, unpleasant taste, nausea, vomiting, abdominal discomfort, diarrhea, constipation, other gastrointestinal disturbances. *Allergic:* Urticaria, rash, ecchymosis, erythema, *Endocrine:* impotence, changes in libido, gynecomastia, menstrual upset. *Hematopoietic System:* Bone marrow depression, agranulocytosis, leukopenia. *Miscellaneous:* A variety of miscellaneous adverse reactions has been reported by physicians. These include complaints such as dyspnea, hair loss, muscle pain, dysuria, increased sweating, and polyuria.

DOSAGE AND ADMINISTRATION: Tenuate (diethylpropion hydrochloride): One 25 mg. tablet three times daily, one hour before meals, and in midevening if desired to overcome night hunger. Tenuate Dospan (diethylpropion hydrochloride) controlled-release: One 75 mg. tablet daily, swallowed whole, in midmorning. Tenuate is not recommended for use in children under 12 years of age.

OVERDOSAGE: Manifestations of acute overdosage include restlessness, tremor, hyperreflexia, rapid respiration, confusion, assaultiveness, hallucinations, panic states. Fatigue and depression usually follow the central stimulation. Cardiovascular effects include arrhythmias, hypertension or hypotension and circulatory collapse. Gastrointestinal symptoms include nausea, vomiting, diarrhea, and abdominal cramps. Overdose of pharmacologically similar compounds has resulted in fatal poisoning, usually terminating in convulsions and coma. Management of acute Tenuate intoxication is largely symptomatic and includes lavage and sedation with a barbiturate. Experience with hemodialysis or peritoneal dialysis is inadequate to permit recommendation in this regard. Intravenous phentolamine (Regitine®) has been suggested on pharmacologic grounds for possible acute, severe hypertension, if this complicates Tenuate overdosage.

Product Information as of April, 1976

MERRELL-NATIONAL LABORATORIES Inc.
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Direct Medical Inquiries to:
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References: 1. Citations available on request from Medical Research Department, MERRELL-NATIONAL LABORATORIES, Cincinnati, Ohio 45215. 2. Hoekenga, M.T., O'Dillon [Dillon], R.H., and Leyland, H.M.: A comprehensive review of diethylpropion hydrochloride. In, Central Mechanisms of Anorectic Drugs, S. Garattini and R. Samanin, Ed., New York, Raven Press, 1978, pp. 391-404.

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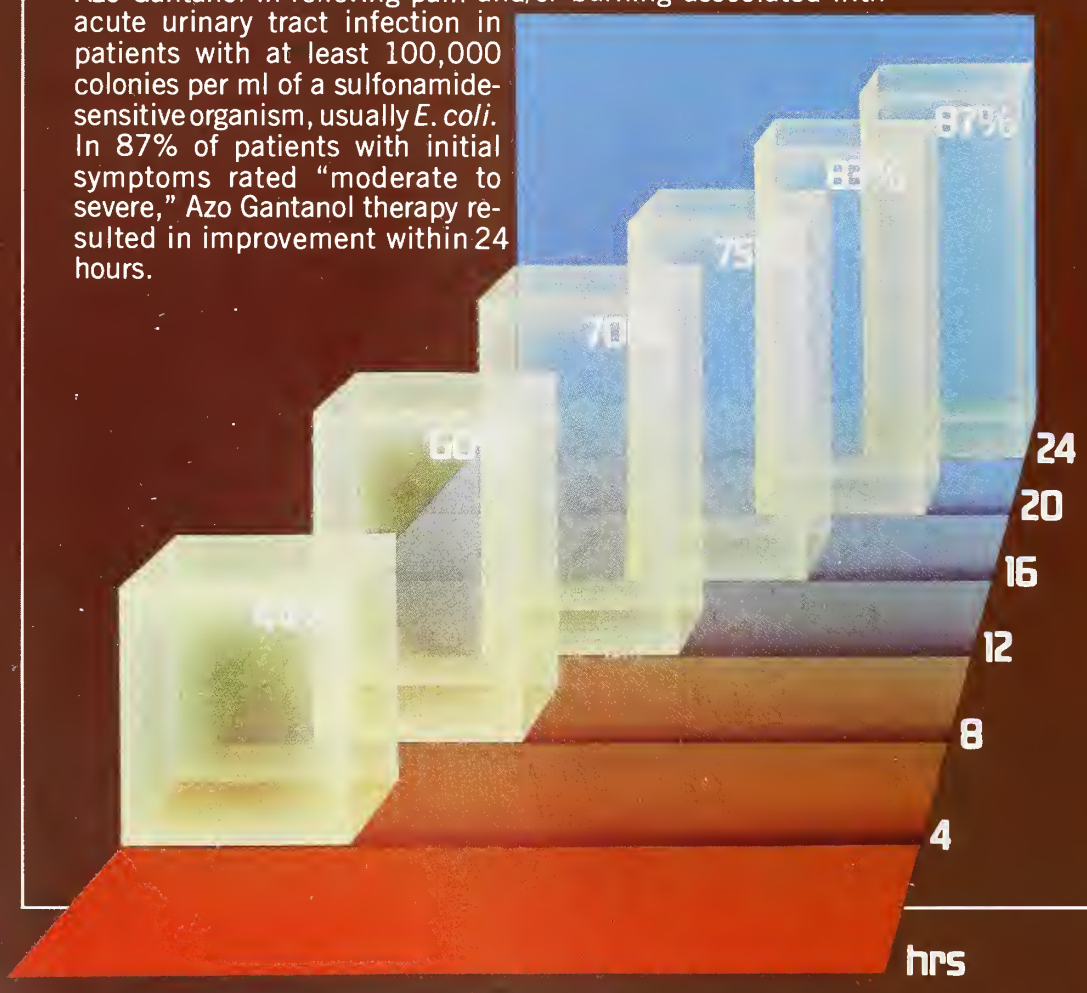
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Indications: In adults, urinary tract infections complicated by pain (primarily pyelonephritis pyelitis and cystitis) due to susceptible organ (usually *E. coli, Klebsiella-Aerobacter, Staph coccus aureus, Proteus mirabilis,* and, less fr quently, *Proteus vulgaris*) in the absence of obstructive uropathy or foreign bodies. **Note: fully coordinate *in vitro* sulfonamide sensitivi tests with bacteriologic and clinical response aminobenzoic acid to follow-up culture media increasing frequency of resistant organisms li the usefulness of antibacterials including sul fonamides.** Measure sulfonamide blood level variations may occur; 20 mg/100 ml should b maximum total level.

Contraindications: Children below age 12; su fonamide hypersensitivity; pregnancy at term during nursing period; because Azo Gantanol tains phenazopyridine hydrochloride it is con dicated in glomerulonephritis, severe hepatit uremia, and pyelonephritis of pregnancy with disturbances.

Warnings: Safety during pregnancy not estab Deaths from hypersensitivity reactions, agran tosis, aplastic anemia and other blood dyscra have been reported and early clinical signs (s throat, fever, pallor, purpura or jaundice) ma dicate serious blood disorders. Frequent CBC urinalysis with microscopic examination are ommended during sulfonamide therapy.

Precautions: Use cautiously in patients with paired renal or hepatic function, severe aller bronchial asthma; in glucose-6-phosphate dehydrogenase-deficient individuals in whom dose-related hemolysis may occur. Maintain adequate fluid intake to prevent crystalluria stone formation.

Adverse Reactions: *Blood dyscrasias* (agran- ulocytosis, aplastic anemia, thrombocytopen leukopenia, hemolytic anemia, purpura, hyp thrombinemia and methemoglobinemia); *alle reactions* (erythema multiforme, skin eruptio Stevens-Johnson syndrome, epidermal necro urticaria, serum sickness, pruritus, exfoliativ dermatitis, anaphylactoid reactions, periorbi edema, conjunctival and scleral injection, p sensitization, arthralgia and allergic myocard *G.I. reactions* (nausea, emesis, abdominal p hepatitis, diarrhea, anorexia, pancreatitis an stomatitis); *CNS reactions* (headache, peripl neuritis, mental depression, convulsions, ata hallucinations, tinnitus, vertigo and insomni *miscellaneous reactions* (drug fever, chills, t nephrosis with oliguria and anuria, periarteri nodosa and L. E. phenomenon). Due to certa chemical similarities with some goitrogens, d uretics (acetazolamide, thiazides) and oral h glycemic agents, sulfonamides have caused instances of goiter production, diuresis and glycemia. Cross-sensitivity with these agents exist.

Dosage: Azo Gantanol is intended for the ac painful phase of urinary tract infections. *Usu adult dosage:* 2 Gm (4 tabs) initially, then 1 (2 tabs) B.I.D. for up to 3 days. If pain pers causes other than infection should be sough After relief of pain has been obtained, conti treatment with Gantanol (sulfamethoxazole) be considered.

NOTE: Patients should be told that the oran dye (phenazopyridine HCl) will color the urin

Supplied: Tablets, red, film-coated, each co ing 0.5 Gm sulfamethoxazole and 100 mg phenazopyridine HCl—bottles of 100 and 5

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JOURNAL
of the medical association of georgia



The MAG — What Is It Doing for *You?*

EARNEST C. ATKINS, M.D., *Atlanta**

The Medical Association of Georgia — the MAG. What specifically is it doing for you — the membership? What influence is it having on the course of important issues in medicine? As a professional service organization, whose function it is to serve the needs and interests of its physician members, what difference is it making in the outcome of political decisions that relate to medicine?

These questions are important, and the answers to them even more so. Within them reside the justification for both our existence and your support. How your Association impacts on the relevant issues of the day influences to a great extent the manner in which you will practice medicine in the future. We see as one of our responsibilities to keep you — the membership — informed about our activities. To that end, in this special article of the *Journal,* we have chosen to discuss several important issues and areas of concern for the MAG.

Public Relations — It has been a busy year for our public relations (PR) efforts at MAG. Each of us daily in contact with our patients establishes, maintains, or destroys the image the public has of doctors. It has been estimated that 95% of any medical association's public relations depends on physician/patient relationship and 5% on the media.

That notwithstanding, we have a viable PR program that includes the establishment of a speakers' bureau; plans for the expansion of the Tel-Med programs to each of the urban areas of the state; a series of pamphlets and brochures to be placed in cooperating physicians' offices explaining such topics as the costs of medical care, "Your Health Is in Your Hands," etc. We have developed a patient "questionnaire" to evaluate how Georgians feel about organized medicine, as well as positive position papers on issues affecting medicine which can be disseminated to all Georgia media. We have supported the resumption of a statewide, health information column to be distributed through the county

* Dr. Atkins is President of the MAG.

medical societies to local newspapers; the organization of open health forums around the state, whereby local physicians hold "town meetings" on health related topics; and the continuation of the statewide physician-interview radio show FOR GOOD HEALTH. We are also planning a public relations workshop in January for county society presidents, presidents-elect, and PR chairmen.

Professional Liability Insurance — The MAG, working actively with the St. Paul Insurance Company for more than 30 years, has provided uninterrupted liability protection for the Georgia physician. Our premiums rank among the lower 25% in the nation. Awards to plaintiffs have reached $500,000 for the first time in Georgia. Because of this, quality medical care to each and every patient becomes vitally important.

Risk Management (How to better manage your risk of malpractice suits) — Under the direction of J. Rhodes Haverty, M.D., we are developing curricula for seminars in this field as part of our effort to reduce the number and severity of malpractice suits filed. The actuarial department of the St. Paul Insurance Company is now working on incentives for physicians to attend these risk management seminars. Such an incentive could be premium reduction in professional liability insurance.

Legislation — This remains one of MAG's top priorities. During the 1979 Georgia General Assembly, over 2,000 bills were introduced and of these, over 100 dealt with some aspect of health care. Your MAG was successful again this past year in that no legislation passed that MAG opposed. Here is a partial list of a few bills that did not pass but will be considered by the 1980 General Assembly in January.

HB 83 Mental Illness Insurance — This bill requires that all accident and sickness insurance policies, both group and individual, make available coverage for the treatment of mental disorders to the same extent that coverage is provided for physical disorders. MAG supports this legislation.

HB 139 Catastrophic Health Care Costs — This bill would provide a means for Georgians to protect themselves against the extraordinary cost of a serious illness or injury and would be made available to persons unable to purchase such insurance protection. MAG supports this legislation introduced by Rep. Roy Rowland, M.D., of Dublin.

HB 228 Chiropractic Insurance — This bill would compel by law that all group and blanket insurance policies of accident and illness also provide coverage for chiropractic services. MAG opposes this legislation.

HB 394 Optometric Use of Drugs — This bill provides that optometrists could use pharmaceutical agents for diagnostic purposes. MAG opposes this bill.

HB 652 Definition of Physician — This bill would restrict use of the title "physician" to only those persons licensed as an M.D. or an osteopath. MAG initiated the legislation.

HB 86 Right-to-Die — This bill would allow Georgians a "Directive to Physicians" to indicate their desire for the physician not to employ or to remove life-sustaining measures under certain conditions. MAG supports the legislation.

SB 217 In-Patient/Out-Patient Insurance — This bill would require insurance companies to reimburse for medical procedures performed on an out-patient to the same degree as said medical procedures are performed on an in-patient. MAG initiated the legislation.

Health Systems Agencies Task Forces — The 1978 and 1979 MAG House of Delegates directed that Physicians' Task Forces be formed in each area of Georgia served by a Health Systems Agency (HSA). These Task Forces are to be composed of MAG members "who are members of the governing body of the Health Systems Agency in its area and other interested and concerned members of the Association" to insure that the decisions made by HSAs are responsive to the medical needs of Georgians. The Task Forces are to work with the HSAs, providing additional physician input into the planning process.

At this time, Task Forces have been organized in the Southeast Georgia Health Service Area and the North Central Georgia and Southwest Georgia areas. Physicians in the Central Georgia and East Central Georgia areas have been contacted to determine their interest in participating in their respective Task Forces. County medical society officials in the Appalachian Georgia Health Service Area will be contacted in the near future to determine their interest in sponsoring a Task Force in their area. Each Task Force will be commenting on specific plans and programs of its respective HSA and will serve as a ready resource of medical expertise for each HSA.

State Health Planning and Development Agency (SHPDA) — MAG has been following closely the activities of this important agency which is responsible for administering the state's Certificate of Need (CON) law and for developing a State Health Plan. This Plan will guide the development of medical services in the state for years to come. MAG has commented on proposed regulations for CON. One such comment involves an objection to the inclusion of specific review criteria in the regulations,

thereby precluding any local planning. Another involves opposition to the use of the "fair market value" of a project rather than its actual cost to determine whether it is subject to review. MAG also objected to the requirement that every facility submit a 3-year plan before a project can be reviewed, and that every project undertaken within 1 year be included in the first year of the plan.

MAG also has submitted its comments on portions of the Draft Preliminary State Health Plan, including sections dealing with general hospital beds, CT scanning, nursing home services, cardiovascular disease, state policy analysis, and primary care services. Many of the comments submitted by MAG will be incorporated into the revised plans. However, federal law mandates that the Plan be "consistent with the National Guidelines for Health Planning," thus limiting MAG impact. Nonetheless, MAG will be commenting on forthcoming sections of the plans dealing with perinatal disease, emergency medical services, mental health, pediatric inpatient services, and radiation therapy.

Medicaid — For several years, MAG has worked with the Georgia Department of Medical Assistance (DMA) to solve many of the problems which traditionally have discouraged physician participation in the Medicaid program. At this time, the main problem is the inequitable reimbursement of physicians.

MAG's Third Party Relations Committee has met with Medicaid officials on numerous occasions to improve this situation. However, regulatory and financial barriers have in the past prohibited resolution of this problem. MAG will be working with DMA officials during the next 2 months to discuss an expected proposal to more equitably reimburse physicians. In addition, MAG will be considering the possibility of requesting that fee profiles used by Medicaid be updated. This has not been done since 1975.

Continuing Medical Education (CME) — MAG's main thrust in continuing medical education is to assist every hospital in Georgia with a staff of at least 20 physicians in developing an accredited CME program. When a hospital's program reaches a certain level of quality, we encourage it to apply for accreditation from the MAG. Accreditation standards are demanding to insure the credibility of the system, and we charge the hospital a $250 or $350 fee (depending on staff size) to pay for our expenses, staff time, and materials. At the heart of the accreditation procedure is a site survey of the hospital by a team of MAG physicians who are involved in CME. The team interviews hospital staff, observes a CME activity, and writes a report for final approval by MAG's Education Committee. As of August 1979, 17 hospitals have been accredited by the MAG. We have also been the agent for accrediting 17 specialty societies, medical societies, and voluntary health organizations.

The MAG has been the accrediting agency in Georgia for CME only since July 25 of this year. On that date the American Medical Association House of Delegates voted to withdraw AMA membership from a national accrediting agency, the Liaison Committee on Continuing Medical Education (LCCME). The AMA reassumed the primary responsibility for accreditation which it had held prior to 1977 and immediately delegated this accrediting authority to the state medical associations. MAG members will be interested to know that the MAG played a key role in these developments. We submitted a resolution at the AMA's 1978 Winter Interim Meeting which called upon the AMA's representatives on the LCCME to urge the LCCME to delegate accrediting authority to the state medical associations, who were in fact doing the bulk of the accreditation surveys for the LCCME. The resolution was adopted, but the AMA encountered difficulties in getting the LCCME to espouse this position. The matter came to a head at the 1979 AMA House of Delegates Meeting where, after 3 hours of debate, the delegates voted to withdraw the AMA from the LCCME.

MAG Scientific Assembly — One important way in which the MAG contributes to CME for Georgia physicians is by coordinating this meeting which is held every fall. It is a demanding task and offers our physicians a great deal. The major work, handled by MAG's Division of Education, involves planning and publicity for the individual programs of 15-20 specialty societies.

Workshops for Residents — This year, in cooperation with the faculty from the AMA's Department of Practice Management, we sponsored three 2-day workshops for young physicians finishing up their residency training. The workshops are designed to cover practical aspects of setting up an office, such as financial accounting, personnel policies, and appointment scheduling.

Health Education — Under the aegis of our MAG subcommittee on Health Education, we have for 3 years been coordinating quarterly meetings of the Group on Health Education, composed of 35-40 leaders from agencies and organizations in this field. One result of our work is the May 1979 issue of the *Journal* on teenage pregnancy. We are currently concentrating on the implementation of legislation requiring comprehensive health education in public schools.

Professional Standards Review Organization (PSRO) — Peer Review — You may think that with the advent of the PSRO, medical review has been delegated to the government. This is not so. The PSRO, as currently operated, delegates most of the review to local hospitals. The MAG is also active in this area. The MAG recently responded to AMA's proposed Criteria Sets for Surgical Procedures. Under a contract with the Department of Health, Education, and Welfare, the AMA, in conjunction with national specialty societies, prepared 191 guidelines for reviewing medical necessity for and appropriateness of related surgical procedures. We believe that guidelines are an acceptable mechanism for initiating medical review, but feel strongly that these guidelines should be developed locally, not at the national level, even by the AMA. There were sufficient other concerns to warrant MAG requesting the AMA that the guidelines not be distributed. The response to our request is pending.

We also work with the Georgia Medical Care Foundation, or separately if indicated, in responding to federal regulations relative to PSRO's — particularly in areas dealing with confidentiality of medical records and sanctions of providers. We also function as the final level of appeal for review of commercial claims for which PSRO review is not mandated.

Medical Practice Potpourri — This division is concerned with anything or anybody that is likely to impact on the private practice of medicine. Because of its review, the MAG recently opposed the development and utilization of a Uniform Ambulatory Medical Care Minimum Basic Data Set by the National Center of Health Statistics.

The investigation of quality care provided in primary health care centers and rural health clinics throughout the state is ongoing. The development of Health Maintenance Organizations is being monitored. We are also closely watching the development of holistic health centers, hospices, and home health agencies.

National Health Insurance remains a continuing threat, but perhaps even more so are some of the federal regulations implementing the laws already on the books. We review these regulations and direct items related to medicine to the appropriate agencies for response.

We also review Joint Commission on Accreditation of Hospitals (JCAH) changes. The 1980 Accreditation Manual for Hospitals (AMH) is now available from the JCAH. We urge all physicians to review the new chapter relating to quality assurance and the newly revised one on hospital-sponsored ambulatory care services.

Voluntary Effort — Your Association provides funds and staff support to the Georgia Voluntary Cost Effectiveness Program, the Georgia "VE." Dr. H. Duane Blair, of Decatur, serves as co-chairman of the State Steering Committee. Dr. Williams McDaniel, of Dalton, and Dr. John O'Shaugnessy, of Macon, also serve on this committee.

Since this program deals primarily with hospitals, the Georgia Hospital Association (GHA) has been involved in its organization and implementation. At the present time, baseline data are being compiled from Georgia hospitals to establish individual hospital goals. We encourage all medical staff to cooperate with their hospitals in meeting these goals.

The MAG is also actively attempting to make physicians, their patients, and the government aware of why medical costs are increasing and what we all can do to help reduce these increases. You will be receiving additional information about some of these activities in the near future.

This is but a sampling of all we are involved in. Our tasks are as varied as the political, economic, and social parameters of the medical profession. We function most effectively on your behalf to the extent the lines of communication between us remain open. We are here to serve your needs and interests. Let us know your views that we may serve you better.



Experience teaches us to be most on our guard to protect liberty when the government's purposes are beneficent.

Mr. Justice Louis D. Brandeis
Opinion in *Olmstead* vs. *U.S.* 1928

A uniform schedule of fees, agreed to in advance for a stated period of time after due consultation between the medical profession and the government, seems to offer benefits which are not offered by the present system of reimbursement.

A Different Approach to Physician Reimbursement for Public Programs

DAVID POYTHRESS, *Atlanta**

THE ENTIRE STRUCTURE of third party reimbursement for medical services in this country is grounded upon the fundamentally erroneous idea that there exists a "free market" for professional medical care. The term "usual, reasonable, and customary charge" embodies the notion that the same market forces of supply and demand, which supposedly determine the price of toothpaste and soy bean futures, similarly work to determine the amount a reasonable physician will charge for any particular medical procedure. This is clearly not the case.

In the first place, medicine is a true profession, in which the thing to be acquired does not have an interchangeable value, such as gravel or peaches, and in which advertising and touting is prohibited, certainly by custom if not by the letter of the law as most recently told to us. Virtually nobody goes "shopping" for medical care. Second, whatever limited validity the notion of "usual and customary" may have had 50 years ago has been eliminated by the pervasive presence of third party payment plans, both public and private, all of which are tied to the idea of a "medical market place" for reimbursement purposes. The theoretical "medical shopper," if he ever existed, has long since been replaced by the union member, Medicaid recipient, Medicare beneficiary, or corporate employee. As such he is either oblivious to the rising cost of medicine or exposed to it only through the intangible and virtually imperceptible marginal increase in monthly paycheck deductions for medical insurance.

Under present federal law, the amount of money payable under Medicaid to a particular physician for a given procedure is the product of a remarkably complex formula. This formula takes into account the individual physician's historical "profile" of billings for the procedure concerned, the "profile" of billings by other physicians of the same specialty in the same geographic area for the same procedure, the amount payable to that physician under the Medicare reimbursement formula (a separate labyrinth) for the same procedure, and a host of other factors. The narrative statement of this formula consumes more than two pages of the Code of Federal Regulations. Its true meaning has been the subject of some protracted and fairly unfriendly litigation between Georgia and the federal government which, let it be known, successfully contended that Georgia had overpaid physicians throughout 1974-75.

The adverse consequences of this Byzantine approach to reimbursement fall into three general categories having to do with: 1) ease of administration, 2) intraprofessional equity, and 3) fiscal responsibility by the government.

The cost of capturing, sorting, storing, and referencing the volume of financial minutiae required by the present system is tremendous. In Fiscal Year 1979, data processing charges accounted for approximately 40% of the administrative budget of the Department of Medical Assistance (DMA), or about $5,350,000, compared to total benefits of approximately $411,300,000. Although physician charges accounted for only about 7.7% of total benefits paid, these relative amounts are indicative of the complexity of the reimbursement systems for all ser-

* Mr. Poythress is Secretary of State of Georgia. He is the former Commissioner, Georgia Department of Medical Assistance (Medicaid). His address is Room 214, State Capitol Bldg., Atlanta, GA 30334.

vices; they do not represent "bureaucratic inefficiency" but rather the cost of efficiently operating a poorly conceived reimbursement system which is written into law. (Incidentally, Georgia's gross per claim processing cost of $.40 is among the lowest in the country.) Another administrative difficulty is the unpredictability of the amount of money the "system" will pay for a particular procedure. Payment amounts are subject to variation resulting from changes in the Medicare formula, changes in "profiles" and, perhaps most frequently, the vicissitudes of miscoding by the physician's staff or DMA staff. Finally, the difficulty in maintaining and monitoring a system of this complexity can result in special problems, such as the recent discovery of an obscure, but fairly pedestrian mathematical error, coded into the system at its inception, which resulted in overpayments to one specialty group for over 3 years.

Payment amounts are subject to variations caused by changes in the Medicare formula and "profiles," and miscoding by the physician's or DMA's staff.

Perhaps the most difficult aspect of the present Medicaid reimbursement system for many physicians to accept is the obvious disparity in amounts paid to different physicians for the same procedure, resulting from the way the formula supposedly analyzes the "medical marketplace." Ironically, the present system exacerbates the generally recognized problem of maldistribution of medical talent by rewarding the urban specialist, and penalizing the established nonurban family practitioner. Some physicians in Georgia receive as little as $4 per office visit, yet this clearly objectionable situation cannot legally be cured by an isolated fee increase, granted *ex parte* by the Commissioner or the Board of Medical Assistance. At present, the only alternative is a wholesale update of the existing system which will only aggravate the existing inequities.

This situation, and its somewhat less objectionable Medicare counterpart, have lead to understandable pressures within the medical community for a predictable and generally uniform system of reimbursement. Questions about "how uniform" such a system might be come quickly to mind. While arguments can be advanced in favor of financial recognition for the "extra cost" of practicing in an urban area or obtaining board certification, they do seem to undercut the obvious advantages of uniformity. Another, more remote issue is whether the geographic area of uniformity might turn out to be greater than statewide — perhaps regional or national. The answer would seem to depend on whether Medicaid is ultimately taken over completely by the federal government. Nevertheless, the resolution of these issues is not crucial to the adoption of a reasonably uniform reimbursement system which is not keyed to an imagined "medical marketplace" statistically fabricated inside a computer.

The third, and perhaps most fundamental objection to the present system is the absence of responsible fiscal controls. Publicly funded health care payments, along with welfare and other "transfer payments," represent a major segment of that 80% or so of the federal budget which is said to be "uncontrollable" because they are tied by law to external indices over which neither Congress nor anybody else has any control. One may wonder whether this is a responsible approach to spending public money, and whether a sweeping public policy which obviously anticipates inflation, if not actually encouraging it, has not contributed to our present inflationary woes. The present system is an open-ended approach to reimbursement in which the payor — *i.e.*, the taxpayers — have no long-range control over the total amount paid for services rendered by the medical community.

This has also led to understandable pressures within government for a system which affords the government a modicum of control over the amount spent, other than by curtailing the scope of coverage or eligibility. Some approach to government spending for health care must be devised which provides more than the short-term benefits of "utilization review" and "peer review," but which stops well short of the government's ultimate fall back position of drastic program curtailment, or worse yet, direct economic involvement in the profession of medicine.

The most fundamental objection to the present system of statewide reimbursement is the absence of responsible fiscal controls.

These various pressures, then, all seem to be in the direction of a reasonably uniform system of reimbursement, which takes into account present and future economic realities without being wed to a mythical "medical marketplace," and in which the government can exercise some degree of active control over the amount of money spent. A uniform schedule of fees, agreed to in advance for a stated period of time, after due consultation between the medical profession and the government, seems to offer the benefits of simplicity, predictability, uniformity, and accountability, none of which is offered by the present system of reimbursement.

While the idea of negotiated fees may carry un-

palatable connotations of "unionism" for some, there is no reason that such an approach to reimbursement for a limited number of patients should render the physician or his relationship to any of his patients any less professional than the present approach which is both intellectually unsound and beyond the control of the physician, the patient, and the government. At the same time, no one can seriously argue that strong concerted activity, both political and economic, is anything new to the medical profession. To be sure, a negotiated approach to fees carries with it the possibility of "monolithic medicine versus monolithic government." That sort of unfortunate confrontation seems unlikely, however, given the private sector stature of the medical profession, on the one hand, and its capacity to politically influence public policy, on the other hand. All things taken together, the mere possibility of such an impasse seems preferable to the known inequities and disadvantages of the present approach to reimbursement.

Whether the type of reimbursement system suggested here can be adopted under the present law is not clear. For the past 2 years, Georgia has been in continuing discussions with the Department of Health, Education, and Welfare (DHEW) on the question of whether such a system can be adopted by administrative action, or whether changes must be made in DHEW regulations or in the Social Security Act. Whatever the final answer may be, it is clear that the present approach to reimbursement cannot be continued much longer. It continues to become more objectionable to more people, both in and out of government. Sooner or later — hopefully sooner — a different approach to reimbursement must be found.

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Cinchona alkaloids, including quinine, have the potential to depress the hepatic enzyme system that synthesizes the vitamin K-dependent factors. The resulting hypoprothrombinemic effect may enhance the action of warfarin and other oral anticoagulants.

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Product Information as of September, 1977

U.S. Patent 2,985,558

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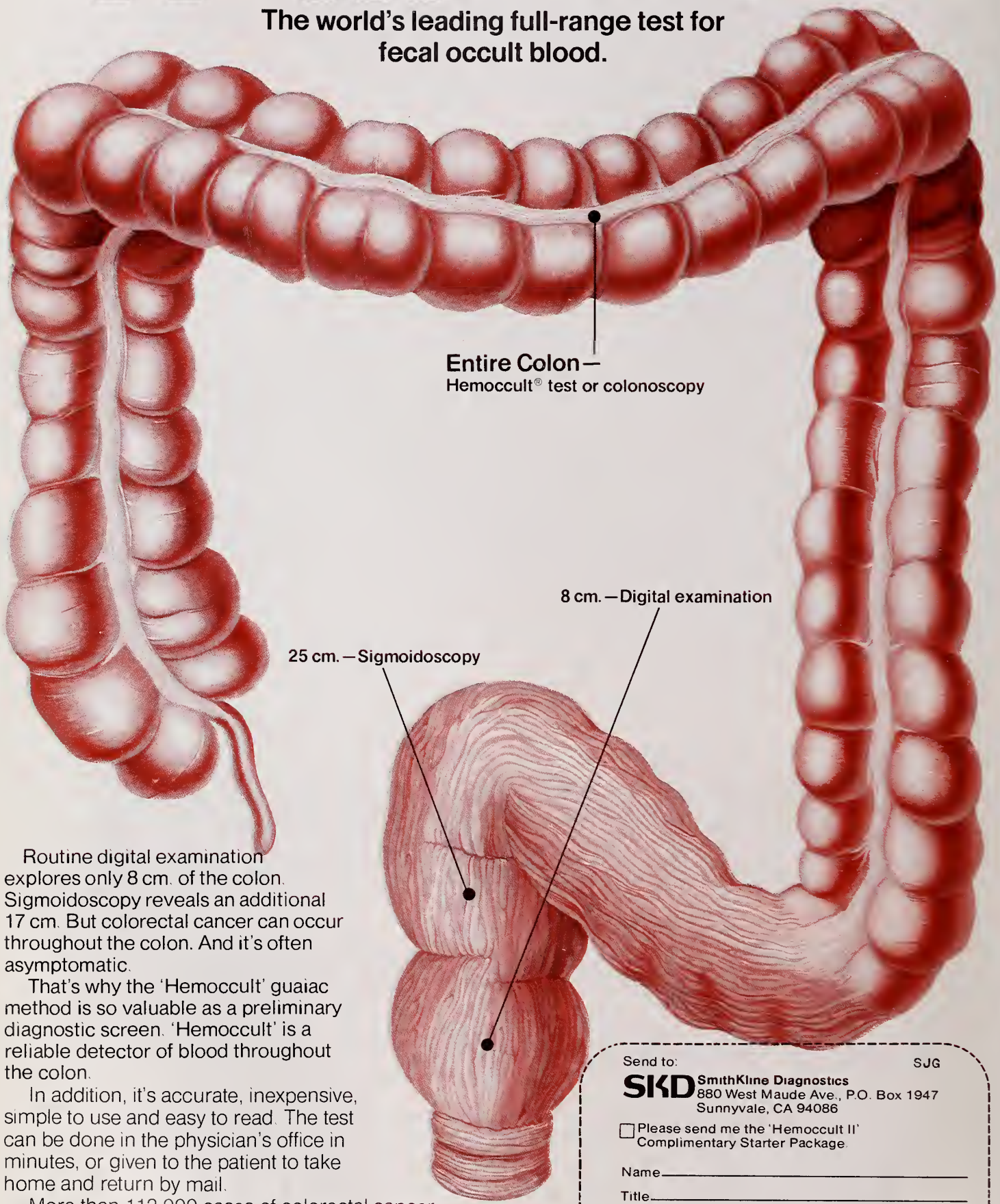
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A cogent presentation of some of the issues surrounding disparate statewide reimbursement of Medicare payments.

Statewide Reimbursement — A View From Medicare

DOUGLASS M. RICHARD, *Atlanta**

In my job, I am often asked such questions as: "Why do you (they mean Medicare, but it always comes out as "you") discriminate between city and rural physicians in Medicare's payments?"

"Why aren't rural doctors reimbursed at the same level as city doctors for identical services?"

"Don't you realize you (read Medicare) are keeping physicians from settling in rural areas by this stupid, discriminatory disparity in fees?"

"What can you (read Medicare) do to bring our rural fees into line with those of the big city boys?"

All of these questions came to mind as I thought about how I could best respond to the request of MAG officials that I set forth in these pages what Medicare has done to assist your Third Party Relations Committee to delve into the mysteries implicit in the above queries. Somewhere in the body of this discourse I'll respond to them. First, though, a few statements about how Medicare reimbursement is determined might be in order, as I have found that most physicians (not you, of course, but most of the others!) really have only a cursory knowledge, at best, about this.

Permit me, then, for a few moments to become somewhat pedagogic. Under the law, medical insurance payments are based on "reasonable charges" for covered services and supplies.

The Medicare carrier for your area (Prudential Insurance Company) determines the reasonable charges for covered services and supplies in your area under a procedure prescribed in the Medicare law. Each year, the carrier reviews the actual charges made by doctors in your area during the previous year. Based on this review, new reasonable charges are put into effect about July 1 of each year.

Here's how reasonable charges are determined: First, the carrier determines the *customary* charge (generally the charge most frequently made) by each doctor for each separate service furnished to patients in the previous calendar year.

Next, the carrier determines the *prevailing* charge for each covered service. The prevailing charge is the amount which is high enough to cover the customary charges in three out of every four bills submitted in the previous year for each service. However, increases in prevailing charges for doctors' services are limited from year to year by an "economic index" formula which relates doctors' fee increases to the actual increases in the cost of maintaining their practices and to raises in general earnings levels.

I referred above to your "area." I could have said "locality," the word used for the geographic area for which Medicare carriers derive the prevailing charges for services. Usually, a locality will be a political or economic subdivision of a state, and it should include a cross-section of the population with respect to economic and other characteristics. Carriers delineate localities on the basis of their knowledge of local conditions and their accumulated history of charging practices.

At one time, Georgia had five localities. Now there are four, comprised of urban and rural areas. Incidentally, where appropriate, different localities are established with respect to different types and levels of services. For example, a carrier may determine that a state has five localities for general prac-

* Mr. Richard is Regional Medicare Director, Health Care Financing Administration. His address is Room 702, 101 Marietta Tower, Atlanta, GA 30323.

titioners' charges, but only one locality (the entire state) for members of a particular specialty. This might happen where there are not enough members of the specialty groups in any one of the five localities to establish a valid basis for deriving the prevailing charges for their services. (Georgia's four localities relate to all practitioners, general practice and specialities alike.)

The prevailing charge is that amount which is high enough to cover the customary charges in three out of every four bills submitted in the previous year.

With this information in mind, let me construct a little historical perspective. Since 1977, this office has been working with MAG's Committee on Third Party Relations to see if current charging data indicated Georgia should be a "one locality" state. The thought was that by considering the entire state as one locality, the disparity in fees between urban and rural localities would be reduced, if not erased. That was a possibility, and it actually happened in a couple of other states. (What most advocates of this move either forgot or never realized, however, is that while it is true rural fees are usually raised when the system is changed to a one-locality state, it is equally true that urban fees are generally lowered. Not always, but more times than not. And this, of course, is not usually well received by the urban physicians.)

Nevertheless, to comply with MAG's request, Prudential compiled and analyzed data on physicians' charges to see whether those figures dictated going to a single, statewide locality. They did not so dictate. As a matter of fact, had we gone the route indicated by the study, our Peach State would have wound up with more, not less, localities. This would have resulted in greater fragmentation, and possibly even greater disparities in reimbursement, a fate no one sought.

Many meetings were held in conjunction with the Committee on Third Party Relations, chaired by Dr. Charles Hollis. Progress on the study, slow though it was, was reported to the Committee. (On at least one occasion the Committee was able to help us, the bureaucrats, break some of the bureaucratic red tape!) Finally, before MAG's Annual Meeting this year, we reported to the Committee that the figures did not warrant the sought-after change to one statewide locality, and this in turn was reported to the House of Delegates. MAG then decided to let the matter rest, at least for the time being.

The Department of Health, Education, and Welfare (DHEW) would like to do what it can to encourage physicians to move into rural areas. Some people seem to think equalizing Medicare's reimbursement fees would strongly influence more physicians to make such a move. Perhaps. I tend to believe, however, that the Medicare reimbursement level is only *one* of the factors involved in a physician's decision of where to set up practice, and that, indeed, it is not a *major* factor.

Study results did not warrant the sought-after change to one statewide locality.

Be all that as it may, we are rapidly approaching a time when all of the above may become moot. It is the announced intention of the Carter Administration to seek legislation that would permit Medicare to drop the usual, customary, and prevailing formula for reimbursement. Instead, authority will be sought to change to statewide fee schedules, probably negotiated between DHEW and the "medical community" (as yet undefined). If this comes to pass, perhaps we will all learn conclusively the extent to which Medicare reimbursement levels influence physicians regarding where they decide to practice.

The MAG is continuing to seek ways to minimize the discriminatory fee problems encountered by the rural and primary care physicians.

Towards Resolving Inequitable Medicare and Medicaid Reimbursements

CHARLES D. HOLLIS JR., M.D., *Albany**

In this issue of the *Journal,* Mr. Douglass Richard, Southeast Director of Medicare, and Mr. Davis Poythress, Secretary of State of Georgia, and until recently Commissioner of Georgia Medicaid, discuss the problems of equity in reimbursement for physician's services under the government medical programs. Both Mr. Richard and Mr. Poythress have met regularly and worked most cooperatively with the MAG Third Party Relations Committee. This committee has been exploring ways in which physicians, especially those in primary care fields serving in smaller communities, can be more fairly compensated for their services. As Mr. Richard and Mr. Poythress point out in their articles, our joint efforts have been repeatedly frustrated by the rather rigid constraints of federal law.

In order to be considered for any change in reimbursement levels, the Department of Health, Education, and Welfare (DHEW) required a complex statistical study of fee patterns throughout the state. As a result of this study, we were informed that a single area, prevailing fee mechanism could not be established throughout the state. Adjustments in fee allowances would require a division of the state into seven, compared to the current four, reimbursement areas. Moreover, the total amount of money allocated for physician services could not exceed that already being spent. The net result was that the rural, primary care physicians would realize insignificant upgrading of their fees, while those practicing in larger populated areas would experience a reduction, and, in some cases a rather large reduction, in their fees.

At this point we are at an impasse, effectively bound to the present system by federal law. As is being pointed out, however, there is strong sentiment in the Senate Subcommittee on Health and in the DHEW to substitute statewide negotiated fee schedules for the usual, customary, and reasonable (UCR) method of reimbursement.

Organized medicine, including the AMA and MAG, has always advocated the UCR concept of establishing fees. The idea was that physicians could be compensated by the government payors more nearly at the level they charge their non-government patients.

Currently, there are several problems inherent in the UCR concept as it is used by public reimbursement programs:

(1) The physician in an area and specialty where fees have been unusually high in the past is rewarded, while the physician who has tried to keep his fees down is penalized.

(2) The physician in a new practice, who has not established a fee profile, is frequently allowed a larger fee in the same community for the same service than is allowed a senior, more established physician.

(3) No allowance is made for additional services provided by a rural physician which are offered and paid for by hospitals in larger cities — i.e., those

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rendered by house physicians, emergency room physicians, specialized nurses, and allied health personnel.

(4) The government still has considerable control over fees by manipulating fee profiles and by yearly re-evaluation of fee allowances.

There are several problems inherent in the UCR concept as it is used by public reimbursement programs.

Perhaps it is time for us in medicine to reexamine our position on UCR. In a free enterprise economy, a physician should be able to contract with his patients for an appropriate charge for his services. The patient, in turn, should be responsible for making arrangements with third party carriers, including the government, for reimbursement of an agreed to amount for expenses incurred. In addition, as long as the patient pays the same tax to the government for coverage, he should be reimbursed on the same scale as his fellow citizens, regardless of the county in which he lives. This equity in reimbursement to the patient is not possible under the UCR system.

By direction of the MAG House of Delegates, the Third Party Relations Committee has continued to seek ways to minimize the discriminatory fee problems suffered by the rural and primary care physicians. Georgia Medicaid officials have informed us that they are working on a method which should give some relief. They should be ready to discuss the matter with us in November. The membership will be informed through the *MAG Newsletter* of new developments.

In the meantime, those who have definite ideas about changes needed should communicate with their senators and congressmen, as they are the ones who will ultimately effect a resolution of these reimbursement problems.

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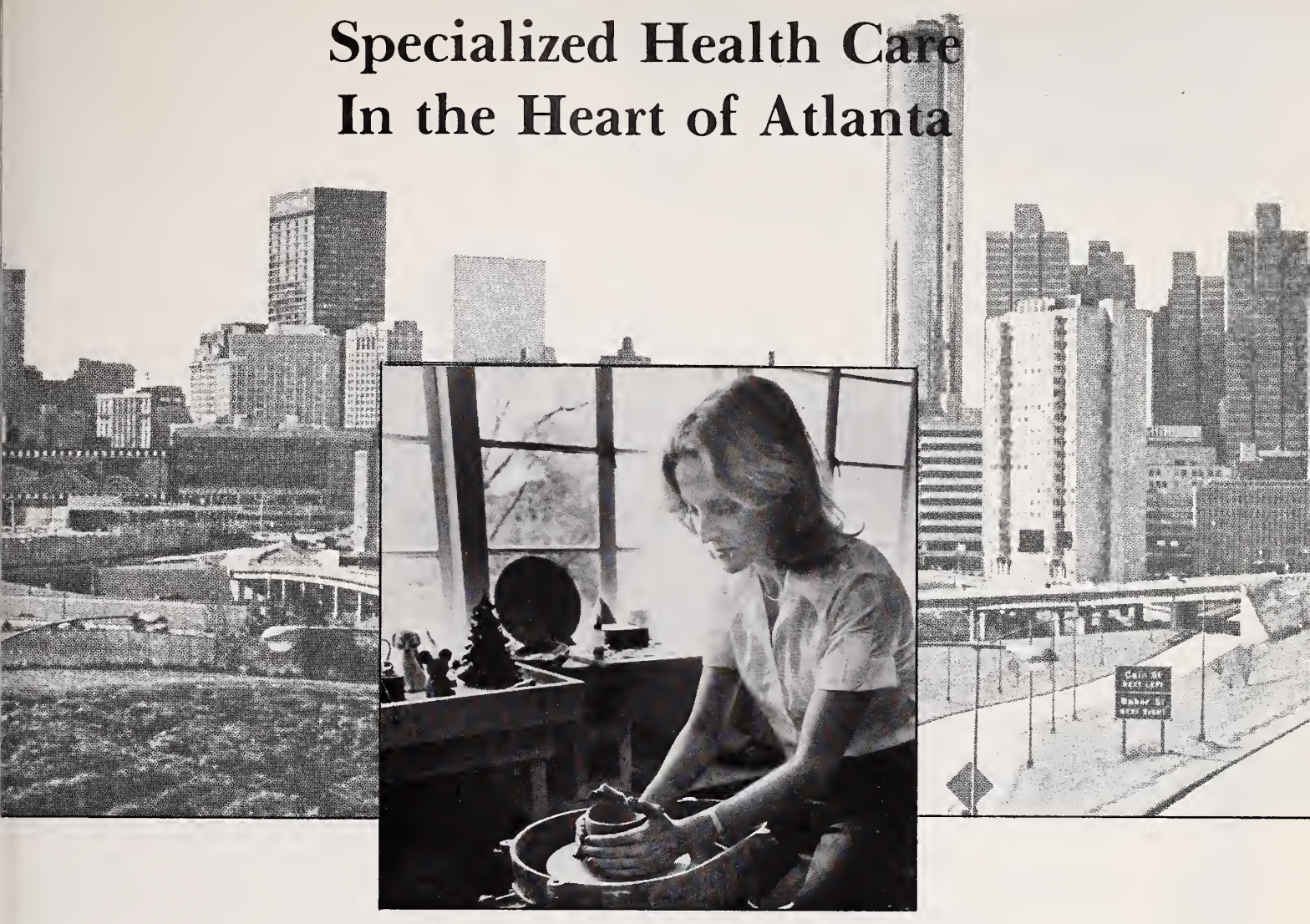
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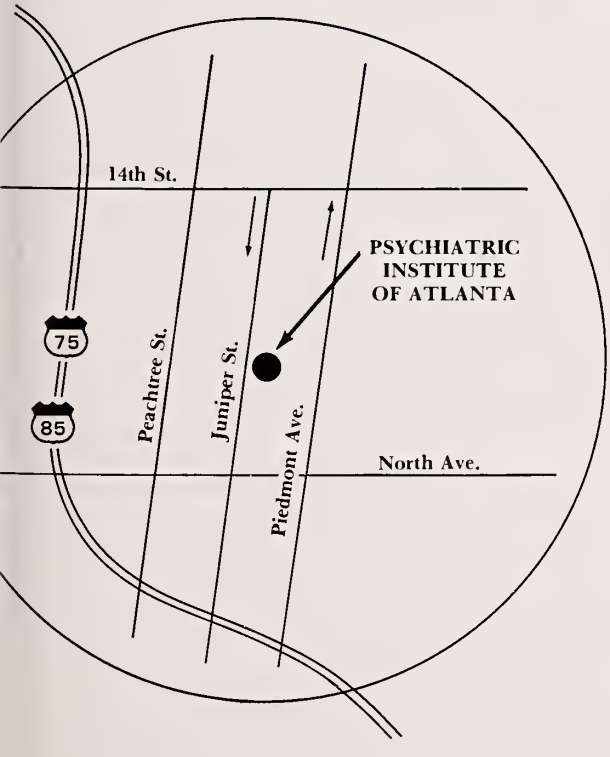
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Exercise programs must be moderate, long-term, consistent, and include proper initial and follow-up testing.

The Value of Exercise in the Practice of Medicine

GERALD F. FLETCHER, M.D., MILTON FRANK III, M.D., S. ROBERT LATHAN, M.D., JOHN D. CANTWELL, M.D., and NANETTE K. WENGER, M.D., *Atlanta**

Introduction

In recent years, exercise has become a major interest of the American public (including those subjects with cardiovascular disease). Exercise may be defined as energy expenditure involving physical activity. It may take the form of running, brisk walking, bicycling, climbing stairs, swimming and other types of active exercise, known collectively as the isotonic or dynamic types. Isometric exercises such as pushups or weight lifting may not be beneficial to the cardiovascular system and indeed may be harmful to the patient with cardiovascular disease.[1]

The benefits of exercise, related in epidemiological studies (Morris et al.[2] regarding bus drivers and conductors, Stamler et al.[3] from Chicago regarding white collar workers, and Taylor et al.[4] on railroad workers and clerks), suggest that more physically active people seem to develop less coronary disease. Prospective studies by Paffenbarger et al.[5] on longshoremen from San Francisco show that heavy work seems to predispose persons to less coronary disease. Even more convincing is their study of Harvard alumni reported in 1977.[6] In this study, Paffenbarger and his associates evaluated by questionnaire 17,000 Harvard alumni over a 6-to-10-year period. They found that those who had energy expenditure equal to or greater than walking up several flights of stairs per day appeared to have a decreased incidence of coronary disease. This decrease in coronary disease was proportional to the intensity of physical activity, irrespective of other factors (except for serum cholesterol levels, which were not known in this group).

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The Effects of Exercise

The physiologic effects of exercise have been well documented.[7] In trained individuals, a decrease in resting and exercise systolic blood pressure occurs. In addition, for a given workload, both resting and exercise heart rate decrease. In trained individuals, an increase in arteriovenous oxygen difference has been observed. This is felt to be a peripheral effect reflecting better efficiency in the peripheral utilization of oxygen. Direct cardiac benefits of exercise relating to this are probably only a secondary effect. The trained individual also has a greater maximum oxygen uptake which reflects an improved total cardiopulmonary performance. With blood lipid levels, there is a consistent response of a decrease in blood triglycerides related to exercise training alone, regardless of other interventions. Blood cholesterol, however, does not usually decrease unless there is dietary modification and weight loss, together with exercise. An increase in high-density lipoproteins also seems positively associated with exercise.

The psychologic aspects of exercise effects are of immense importance and, although scientific data are limited, the emotional state and the "pleasing effect" that one derives from exercising seem to be beneficial. Trained patients have decreased plasma norepinephrine and epinephrine levels both at rest and with exercise.[8]

With regard to specific cardiac effects of exercise there is little data to support a direct effect on the myocardium or on the coronary circulation. There is a clinical impression suggesting that the trained person has fewer complications in the event of a cardiac event such as a myocardial infarction; however, this could be a multi-risk factor type of effect and not due to exercise alone. It is likely that the regularly exercising person also does not smoke, moderates his dietary intake, is not overweight, and has a total health enhancement program with regard to all other factors, and not just exercise alone.

Another important effect of exercise in the coronary patient is that the anginal threshold may be increased.[9] In this study, repeat exercise testing was done in patients with known angina pectoris. After a training effect was achieved, their level of work was increased for the same anginal threshold.

Groups in Consideration

Groups in consideration for exercise are the healthy, or allegedly healthy people, the coronary prone individuals, the myocardial infarction group, and the myocardial revascularization group.

The healthy person is frequently a "coronary prone" person who has not had these factors recognized or documented. These people often exercise in local YMCA's or "on their own." They do not necessarily need an exercise test unless they are above the age of 30 or 35 or unless they have a high coronary risk profile, regardless of age.

The coronary prone group includes individuals with a history of high blood pressure, cigarette smoking, familial early coronary disease, hyperlipidemia, diabetes mellitus, and overweight. These persons should have an exercise test and a medically advised (and sometimes supervised) exercise program.

Carefully-selected post-myocardial infarction patients may enter medically supervised exercise programs by referrals from their physicians. They may begin exercise after testing as soon as 3 to 4 weeks after the occurrence of a myocardial infarction. The programs seem beneficial especially with regard to regaining and maintaining functional capacity.

The most recent group for consideration are patients with **myocardial revascularization** (that is, aorto-coronary bypass surgery). It is felt that exercise and total risk-factor modification is very important in this group. Exercise should be medically supervised — certainly for the therapeutic period after the revascularization procedure. Proper testing and adherence to an exercise prescription with supervision is important. Frequently, patients with good left ventricular function, after successful revascularization, may rapidly advance to maintenance programs.

Other groups of patients — those with stable angina pectoris, pacemakers, prosthetic valves, or with stable acquired valvular disease, such as mitral regurgitation and aortic regurgitation — may benefit from exercise. These patients should be individually evaluated by their physicians and referred if felt appropriate.

The Individual Exercise Prescription

The fundamental assessment involved in the individual exercise prescription is the exercise test. The exercise test is especially useful in individuals more than 35 years of age. A testing device such as a bicycle ergometer, or more often, a motorized treadmill, is used. A maximal or submaximal workload may be utilized but the maximal workload designed for the particular individual is ideal. The test is generally quite safe but should be closely monitored by a physician based on guidelines of the American Heart Association (AHA).[10] Specific contraindications include aortic stenosis, acute myocarditis, recent myocardial infarction, pulmonary embolus, or current febrile illness. False-negative and false-positive exercise tests (indeterminant tests) must be taken into consideration. (Hyperventilation, diuretics, and digitalis may cause false-positive tests.) The physical examination may support a diagnosis of myocardial ischemia with post exercise findings of dyskinesis, papillary muscle dysfunction, murmurs, and gallop rhythm. It is very important to detect systolic murmurs that might suggest hypertrophic subaortic stenosis. The latter is felt to be a cause of sudden death, especially in young people. When such a murmur is detected, further evaluation, especially echocardiography, should be advised. It is strongly encouraged that YMCA and health clubs perform exercise testing only after the above mentioned medical evaluation. Medical supervision for exercise is required for patients who are post-infarction, post-revascularization, or at high coronary risk. Guidelines from the AHA are available for such programs.[11]

Cardiovascular training exercises that may be considered are referred to at times as aerobic or dynamic exercises. Such exercise is not confined to running. Alternatives include cycling (both stationary and conventional), swimming, skipping rope, and perhaps even recreational sports such as volleyball or tennis. Regular prescribed exercise should be at least three times weekly with a dynamic component of 20 to 30 minutes each time. The object of the exercise prescription is to attain a certain target heart rate during this dynamic sequence based on treadmill heart rate attained during testing.

This target heart rate should be 75-85 percent of

the maximal heart rate attained with testing. For example, for a maximal rate of 170/beats per minute (BPM) reached on the treadmill, the target heart rate should be 128-145 BPM. This rate should be maintained for 20 or 30 minutes three times weekly during the dynamic phase of the exercise program.

Dangers, Abuses, and Misuses of Exercise

Many complications of exercise seen by physicians now involve the musculoskeletal system. The importance of stretching, warm-up, and cool-down exercises to prevent such problems cannot be overemphasized. In the middle to older age group, the musculoskeletal system is of great importance and may impair one's compliance to exercise if not taken into consideration. There is no definite data on the long-term effect of exercise on the musculoskeletal system but moderation is suggested. Important ancillary aspects are proper shoes and clothing. Many non-cardiac problems have been reported such as jogger's heels, runner's knees, tendinitis, muscular sprains and strains, and other injuries resulting from improper stretching, poor running surface, and obstructions in running areas.

Cardiac complications of exercise include electrical instability, infarction, and sudden death. Ventricular fibrillation is usually not associated with myocardial infarction but does occur in the setting of severe coronary disease. This is usually the result of exercise-related ischemia which is immediately reversible. Program analyses across the United States have shown that ventricular fibrillation occurring in programs for cardiac patients which are medically supervised is probably less than that in the general population.[12] Reports of individuals who die during or immediately following exercise have generated much concern among the exercising population. If one looks carefully at the people described in these reports, however, it is usually clear that a large percentage of them have significant coronary artery disease. Had they been given exercise tests, it is possible that in many cases, potential dangers of exercise would have been apparent and more appropriate exercise guidelines given.

General Comments and Summary

As exercise becomes more popular, physicians must give appropriate recommendations. The importance of exercise testing should be stressed. Exercise includes extremes from marathon running to a regular daily walking program. Levels and extremes must be tailored to the needs of the individual. Exercise equivalents are important. Many people do not have the desire to run or become bored with running. Bicycling, swimming, tennis, skipping rope, and other activities can be done in equivalent fashion.

Exercise programs must be moderate, long-term, consistent, and include proper initial and follow-up testing. Medical supervision for cardiac groups and exercise prescriptions for all groups are important, and only through these safeguards will proper energy expenditure and exercise programs be developed for the general benefit of the American public.

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The author discusses potential hazards implicit in the use of this drug and specifies appropriate dosage regimens.

Gentamycin Toxicity — Fact or Fiction?

ALAN S. CLEPPER, M.D., *Columbus**

Is THE QUESTION posed in this title a bit misleading? Perhaps so, especially if it were taken to imply that the physician may not need to concern himself with the reported toxicity of gentamycin. This drug has for some years been a drug of choice in the treatment of serious infections and life-threatening sepsis because of its potent, wide-ranging action, particularly against aerobic gram-negative organisms. The pharmacokinetics of gentamycin have been well studied, and from the beginning, the relatively narrow range between therapeutic and toxic levels was recognized as a problem in the effective use of the drug.[1] Peak serum levels following the injection of 80-100 mg of gentamycin range from 5-10 μg/ml, and are seen at 45-60 minutes after intramuscular (IM) injection and 15-30 minutes after intravenous (IV) administration. Gentamycin is not metabolized in the body and is eliminated almost exclusively by renal glomerular filtration. The serum half-life (t½) of a dose given IM varies from 1.75 to 3.5 hours if renal function is normal, but may be as long as 48 hours if there is severe renal impairment.

Both premature and full-term infants do not eliminate gentamycin as rapidly as adults. The average gentamycin serum half-life for full-term infants is 4½ hours, while for premature infants it is 6 hours.[2] The drug is well distributed among the various body fluids, and high gentamycin levels can be produced in the urine. Gentamycin crosses the placenta by passive diffusion, and peak cord blood levels of 35-50% of the maternal serum level can be achieved. Bile, pleural, and pericardial fluid concentrations of gentamycin range from 25 to 50% of the serum concentration. Ocular humor and cerebral spinal fluid concentrations of gentamycin administered IM, however, are inadequate for therapeutic results.

The time at which peak concentrations occur and their magnitude above the preinjection level do not differ even in the presence of renal impairment. At a given daily dose, however, peak serum concentrations vary considerably among individual patients, even in the presence of normal renal function. One of the important variables affecting peak serum concentrations is the patient's hematocrit. Low hematocrits tend to produce high peak serum levels, and high hematocrits will produce low serum levels. Quantitatively, alterations of 5 points in the hematocrit will raise or lower serum gentamycin levels by about 2 μg/ml. Paradoxically, even though anemia will elevate the peak serum level, the anemic patient will show a lower than normal gentamycin serum t½.

Another important factor in variable dose responses is the presence of fever, which will result in not only lower than expected peak serum level with any given dose but also a decreased serum t½. Most likely, the hyperdynamic state associated with acute illness, fever, and anemia results in more rapid distribution of gentamycin into and out of tissue compartments.

Since gentamycin is eliminated mainly through the kidneys, the glomerular filtration rate is obviously an important determinant of the magnitude and

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duration of the serum concentration peak resulting from any given dose of the drug. The direct dependence of the excretion of gentamycin on renal function has led to the development of various nomograms, based on creatinine clearance or serum creatinine concentration, for the determination of dosage in the presence of renal insufficiency. The nomograms can be very useful in the absence of the availability of serum gentamycin levels, though recent experiments have proven the relatively poor predictability of the t½ of gentamycin from serum creatinine concentrations and only somewhat higher correlations when the creatinine clearance and hematocrit are taken into account.[3] Thus, despite the initial enthusiasm, there can be no doubt that the pharmacokinetics of gentamycin may not be adequately predictable from standardized equations or nomograms.

A very important factor relating to gentamycin ototoxicity is renal insufficiency.

Toxicity was common in the early experiences with gentamycin. Many physicians became very cautious in the use of the drug, especially when the patients had some degree of renal insufficiency. Accumulated experience now supports the estimate of the incidence of gentamycin nephrotoxicity of 2%. The toxic effect is that of impairing protein and lipid synthesis, causing swelling, degeneration, and eventually necrosis of the epithelial cells of the renal convoluted tubules. Toxicity is manifested by proteinuria, decreased urine osmolality, rising serum creatinine and BUN, and reduced creatinine clearance. Although the effects on renal function can be devastating, the toxic effect appears to be largely reversible.

Actually, ototoxicity should be of greater concern than nephrotoxicity. This adverse reaction to gentamycin affects the vestibular apparatus, leading to symptoms of giddiness, nausea, vomiting, vertigo, and loss of equilibrium. These symptoms are usually manifested after several days to a week or more of therapy. The best estimates of the incidence of ototoxicity are between 2½ and 3%. The toxic effects are frequently not completely reversible, and there are reports of complete bilateral loss of labyrinthine function. High tone hearing loss has been very rarely reported.

In addition to ototoxicity and nephrotoxocity, there have been rare reports of neuromuscular blockade and hypersensitive reaction associated with gentamycin therapy. Thus, there seems to be no doubt as to the potential toxic phenomena that may ensue from the use of this drug.

Most often, gentamycin nephrotoxicity occurs in patients with pre-existing renal damage (often without adequate dosage reduction). Furthermore, many of the patients in whom renal failure developed while on gentamycin were concomitantly being treated with other antibiotics, frequently cephalosporin. Moreover, many of the patients in whom gentamycin was incriminated as the toxic agent suffered from other conditions also capable of inducing acute renal failure. Most importantly, the majority of these patients did not have the advantage of clinically useful, i.e. accurate and timely, serum gentamycin assays. In those patients in whom serum gentamycin levels were known, a consistent pattern emerges of peak levels of 12μg/ml or above and/or trough levels exceeding 1.5 μg/ml.

A very important factor relating to gentamycin ototoxicity is renal insufficiency. Ototoxicity has seldom been reported in the absence of some degree of primary renal insufficiency. Very probably, ototoxicity has developed in some patients as a consequence of gentamycin-induced nephrotoxicity. As with the nephrotoxic patients, serum gentamycin levels were usually not available, but when serum levels were obtained, sustained trough values exceeding 1.5 μg/ml and/or peak values exceeding 12 μg/ml were identified.

The overriding factor relating to gentamycin toxicity is obviously the dosage regimen. Regardless of renal function, toxicity is the direct result of sustained high serum levels. It is vitally important to adjust dosage regimens to keep peak serum levels below 12μg/ml and trough levels below 1.5 μg/ml. Since individual patients tend to maintain a consistent and essentially linear dose response, alterations in dosage will produce predictable changes in the serum concentration. Gentamycin levels need not be checked frequently, therefore, except in patients with changing renal function. Patients will not become toxic if their serum levels are maintained below the well-defined toxic concentrations.

Regardless of renal function, toxicity is the direct result of sustained high serum levels.

From these data it is clear that while the existence of gentamycin toxicity should be understood and well appreciated, the "toxophobia" of earlier days is now the preserve of the uninformed.[4]

As we see, much emphasis has been placed on the dangers of overtreatment of infected patients with gentamycin. The dangers of undertreating a patient with such an infection are being increasingly, if belatedly, emphasized and may be as significant as that of overtreating. In our experiences, since establishing routine gentamycin assays at The Medical

Center, undertreatment is much more common than overtreatment.

Published experiences based on serum inhibitory concentration (MIC) sensitivity measurements, serum gentamycin levels, and clinical responses lead to the consensus that peak serum levels of less than 4 μg/ml are unlikely to be completely effective. Although most physicians routinely request sensitivity tests, they have not established the practice of observing the antibiotic level during treatment to ensure that the initial dosage is adequate and that proper modifications are made in the maintenance dose to achieve optimal therapeutic, yet nontoxic, levels.[5]

In addition to the prolongation of the infected patient's illness, with its greater risk of complications, undertreatment portends to a very real danger of the emergence of resistant strains of organisms. Though it is still an unusual occurrence, we have seen at The Medical Center a Pseudomonas growth change from very sensitive (MIC 0.5 μg/ml) to resistant (MIC 32 μg/ml) over a 5-day period.

One of the important variables affecting peak serum concentrations is the patient's hematocrit.

Paraphrasing a recent review reflecting the literature consensus on the prescription of gentamycin, it is recommended that initial doses be given at 8-hour intervals on the first day according to a mg/kg formula (1.2-1.5 mg/kg per 8-hour dose).[6] Before the 4th or 5th dose, and 1 hour after it for IM doses or ½ hour for IV doses, serum specimens should be collected, and the trough and peak levels of the drug determined. In the treatment of infections other than those of the urinary tract, the peak level of gentamycin should exceed 4 μg/ml and be less than 12 μg/ml; the trough concentration is more individually variable but should exceed the mean inhibitory concentration for the infecting organism. The dose can be adjusted in adults with the expectation that an increase or decrease of 2 mg/kg in the total daily dose will produce a twofold rise or fall in the peak serum concentration. The frequency with which subsequent assays are performed should be determined by the clinical response, the duration of treatment, and especially any changes in hemodynamic or renal function.

Following these guidelines, it appears that even though gentamycin toxicity is fact and not fiction, the patient can benefit from both safe and effective therapy.

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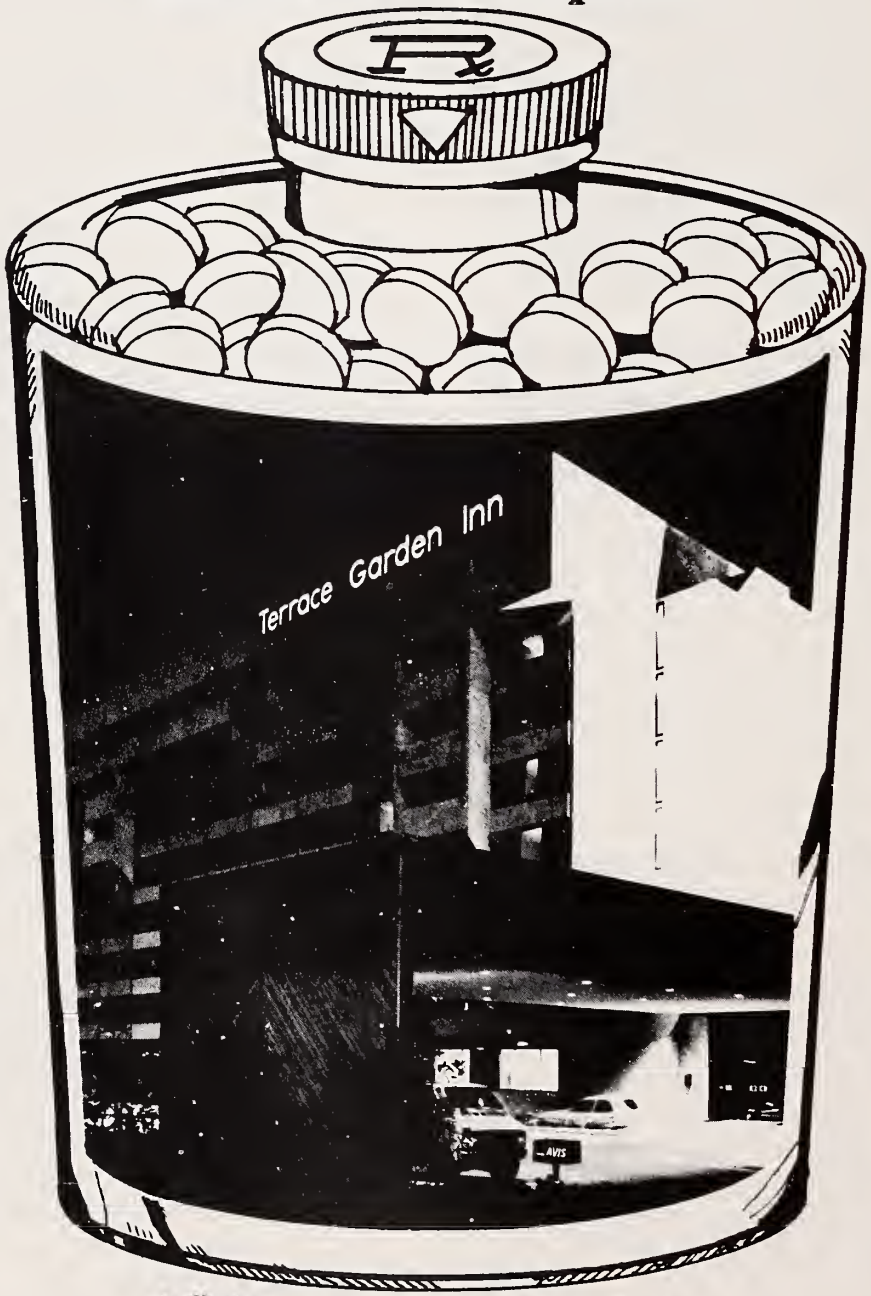
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Acoustic neuroma surgery is relatively safe and effective because of improved neuroanesthetic and microsurgical techniques.

Acoustic Neuroma — Current Diagnosis and Treatment

LAWRENCE B. SCHLACHTER, M.D., JOHN PER-LEE, M.D., and GEORGE T. TINDALL, M.D., *Atlanta**

Abstract

Acoustic neuroma is a relatively rare, benign lesion which can be cured with present day microsurgical techniques. The once high mortality rates associated with resection in past years have been reduced to less than 1%, and facial nerve function can be preserved in a majority of cases. This article reviews recent advances made in the diagnosis and treatment of this type of lesion.

Introduction

In recent years, there have been several important advances in neurosurgery and neuroradiology. These improvements have enhanced the accuracy of neurodiagnostic techniques and significantly reduced the morbidity and mortality associated with neurosurgery. These diagnostic innovations, particularly the computerized tomography (CT) scan and microsurgical techniques, have had a substantial influence in the management of brain and pituitary tumors, spinal cord lesions, and intracranial aneurysms. This impact is especially apparent in the diagnosis and treatment of acoustic neuromas in which polytomography, CT scanning, and cerebellopontine angle myelography have allowed earlier and more precise diagnosis. Microtechniques and the operating microscope have not only reduced morbidity and mortality but, in the majority of cases, have also made it possible to completely remove these benign lesions and preserve facial nerve function. The significant progress and changes made in the diagnosis and treatment of acoustic neuromas justify a review of the current management of this type of lesion.

Historical Aspects

Acoustic neuroma was first reported by Sandifort in 1777.[1] In 1830, Bell[2] described the slowly worsening clinical course of a 21-year-old woman in whom cranial nerve involvement and headache developed, followed by signs of brain stem compression. The patient died. Autopsy revealed a tumor the size of a pigeon's egg bounded by the petrous portion of the temporal bone, pons, and cerebellum. Over half a century later, Ballance[3] performed a suboccipital craniectomy and removed a cerebellopontine angle tumor which on examination proved to be an acoustic neuroma. Although the patient lost 5th and 7th nerve function and later had to have her ulcerated eye enucleated, she survived. This report, published in 1894, was the first account of successful surgery for an acoustic neuroma.

The mortality associated with early operations on acoustic neuromas was very high, in some cases greater than 70%. Cushing,[4] who developed the technique of intracapsular removal, reduced the mortality to 20% in his early cases. During the 1940's, particularly the latter part, mortality was reduced to 4%, an accomplishment attributed to electrocautery, suction, and improved anesthetic techniques. Advances in the 1950's were primarily diagnostic. In the early 1960's, House[5] introduced the middle cranial fossa and translabyrinthine approaches to the internal auditory canal and at the

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same time demonstrated the importance of the operating microscope in acoustic neuroma surgery. Meanwhile, Rand and Kurze[6] adapted the microscope to the classical suboccipital posterior fossa craniotomy and added a drilling technique to open the internal auditory canal from its posterior side. This approach, which provides excellent exposure of the 7th and 8th cranial nerves as well as the usual extension of tumor into the canal, is employed by most neurosurgeons today.

Pathology

The acoustic neuroma is a benign, encapsulated neurilemmoma which usually originates from Schwann cells of the vestibular division of the 8th cranial nerve within the internal auditory canal. On gross examination, these tumors are encapsulated, usually yellowish brown on cut section, and either soft or tough in consistency. The size of the tumor varies from small intracanalicular lesions to extremely large masses that compress and distort important neighboring structures such as the brain stem. When a tumor is large enough, it blocks the flow of cerebrospinal fluid (CSF) and causes obstructive hydrocephalus.

Acoustic neuromas account for 8-10% of all brain tumors and approximately 75% of all cerebellopontine angle tumors.[7] The tumor is most common in patients aged 40 to 60 years, with no sex preference. Characteristically, a portion of the tumor is located within the internal auditory canal, an important fact to remember when performing surgery if total tumor excision is to be accomplished. Other lesions to be considered in the differential diagnosis of a cerebellopontine angle mass lesion include meningioma, cholesteatoma, metastatic tumor, glomus tumor, choroid plexus papilloma, neuroma of the 5th cranial nerve, arachnoid cyst, and aneurysm.

Clinical Findings

Acoustic neuroma symptoms result from compromise of the neural and/or vascular structures within the internal auditory canal. Compression of the internal auditory artery which accompanies the 7th and 8th cranial nerves into the canal can cause end-organ ischemia, but early cochlear and vestibular dysfunction is due to nerve compression within the canal. Early symptoms include unsteadiness, vertigo, tinnitus, and progressive unilateral sensorineural hearing loss.[8, 9] As the tumor enlarges, it tends to erode the walls of the internal auditory canal and grow medially into the cerebellopontine angle (Figure 1). Even though the enlarging tumor stretches the 7th cranial nerve, facial nerve palsy is unusual. More commonly, the tumor impairs sensory function in the 5th cranial nerve which is manifest by either loss or impairment of the ipsilateral corneal reflex.

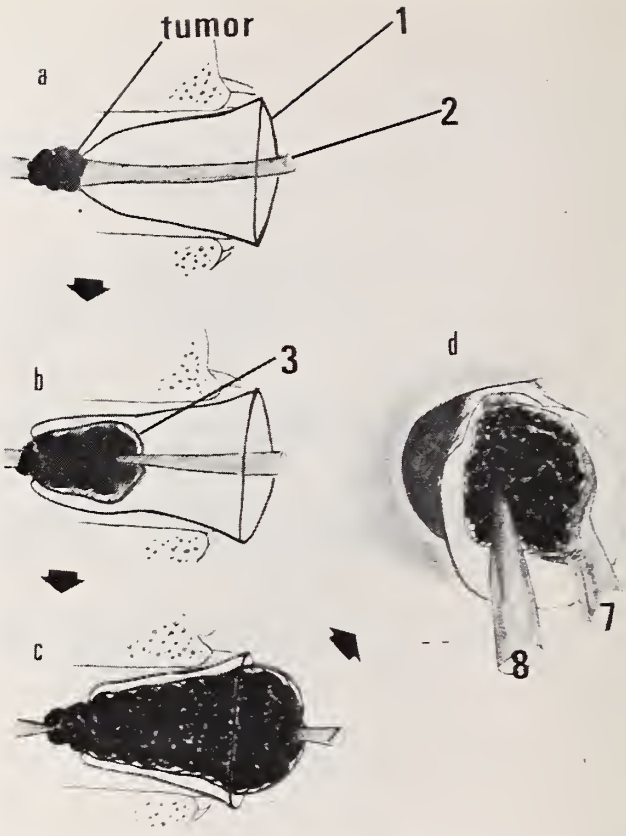


Figure 1 — Representation of an acoustic neuroma (3) arising within the internal auditory canal in proximity to the nerves (2) growing medially into the cerebellopontine angle. Arachnoid membrane (1) invaginates into the canal. The facial nerve (7) is splayed in an anterosuperior and anteroinferior direction. Vestibulo-acoustic nerve (8) seen posteriorly in canal. Source: DiTullio.[22]

Acoustic neuromas may present with other symptoms of cranial nerve dysfunction, such as reduced blink response, decreased taste, diminished lacrimation, nystagmus, palatal weakness, sternocleidomastoid or trapezius muscle weakness, decreased sensation of the face, and facial pain. Signs of cerebellar compression which occur infrequently include ataxia, speech disturbances, difficulty with fine motion of the hands and rarely, hypotonia and intention tremor.

Otologic Evaluation

As the initial manifestations of acoustic neuromas are almost invariably related to 8th nerve impairment (i.e., hearing loss, tinnitus, and vertiginous dizziness), comprehensive auditory and vestibular testing are important. Such evaluation can detect small tumors before they threaten other structures.

Therefore, one asks about and looks for unilateral sensorineural hearing loss and dysequilibrium, maintaining a high index of suspicion for tumor if either or both findings are present. Test results usually conform to a pattern, but since exceptions can occur it is wise to enlist the aid of one experienced in the diagnostic evaluation. The practitioner, however, can with a 250 frequency tuning fork seek clues

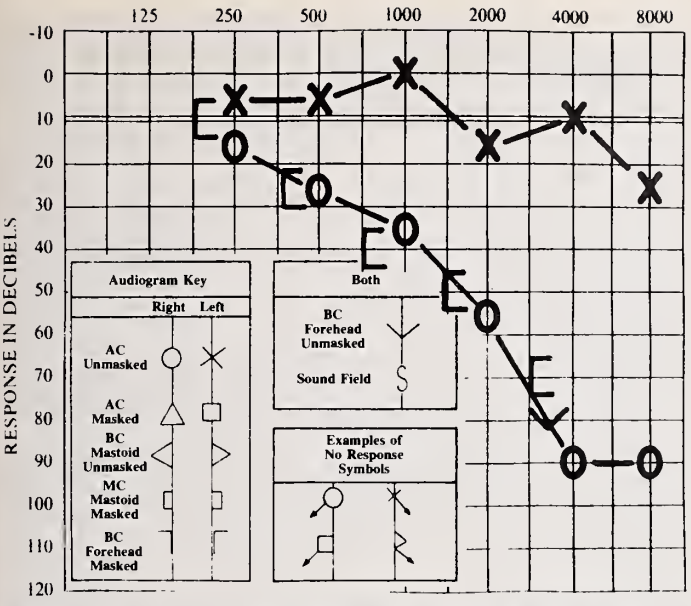


Figure 2 — Type III Bekesy audiogram from a confirmed acoustic neuroma, showing characteristic pattern of loss of adaption at high frequencies in involved ear.

to help establish the cause of the expected hearing loss. One first ascertains whether a hearing loss is sensorineural. By simply comparing air conduction with bone conduction, as is done with the Rinne test, a relationship will emerge. Sensorineural hearing losses produce a response in which subjective loudness of air conduction is greater than bone conduction. One then places the stem of the tuning fork on the center of the head. The sound of the tuning fork should lateralize away from the involved ear. In other words, the patient will hear the bone conducted sound applied by the tuning fork stem in the opposite ear. One assumes for an acoustic neuroma that a pure tone threshold test will confirm a sensorineural hearing loss. Such is contrasted, of course, with normal hearing or conductive hearing loss (Figure 2). While neuroma-induced loss more commonly favors the high frequencies, there is no typical pattern.[10] One proceeds, then, to differentiate the loss as cochlear or retrocochlear. Retrocochlear disease, of which acoustic neuroma is an example, characteristically produces auditory habituation of fatigue. The specific tests and expected results are listed in order of sensitivity in Table 1.

Evoked response audiometry, the most recent addition to the battery of tests, pinpoints retrocochlear disease more accurately than any other.[11] The test is not infallible, however, and Selter found false-positive and false-negative results in 3 and 8%, respectively.[12] Glassock reports that 19 of 20 confirmed acoustic neuromas had a positive result.[11] Finally, a comprehensive audiologic examination routinely includes a measure of a speech discrimination. An inordinate impairment of an ear's measured threshold raises the suspicion of tumor.

Since acoustic neuromas develop more commonly

TABLE 1 — Audiometric Tests to Detect Retrocochlear Disease

Test	Expected Result
Evoked Response Audiometry[11, 12]	A delay of 6 milliseconds in V wave of evoked response
Reflex Tone Decay by Impedance Audiometry	A threshold decay of 50%
Bekesy Comfortable Loudness Test[13]	Characteristic separation of continuous and interrupted tracings
Standard Tone Decay[11]	Decrement of thirty decibels in 1 minute
Bekesy Threshold Test[12]	Characteristic separation of continuous and interrupted tracings

on the vestibular branches of the 8th cranial nerve, one would expect testing to reveal a vestibular deficit early in tumor growth. While vestibular testing techniques unfortunately are not as sensitive as those used for hearing loss, they are still of value in aiding diagnosis. The intensity of nystagmus induced by caloric testing of the two ears is compared. Whether the stimulus is warm, cool, or cold, the involved ear tends to show less response than its counterpart. Most laboratories utilize recording equipment, the electronystagmograph, to better quantify and compare results. The non-specialist physician can make an assessment by stimulating each ear with 0.5 ccs of ice water placed in the external canal for 30 seconds. The patient should be lying supine with the head elevated 30 degrees from the horizontal and turned to the side. At the end of 30 seconds, the head is turned to empty the canal. The amplitude and frequency are estimated, the duration measured, and these parameters then compared with the other side. It is better to wait 5 minutes between stimulations of the separate ears. The results will be more accurate if the patient has not taken sedatives, antihistamines, or psychotrophic drugs within 2 days of the test.

Neurodiagnostic Evaluation

Valuable neurodiagnostic studies include plain skull roentgenograms, hypocycloidal polytomography of the internal auditory canal, CT scan, and CPA myelography. Since the CT scan became available, pneumoencephalography and/or ventriculography are rarely, if ever, indicated in the diagnostic evaluation. Vertebral angiography performed via the transfemoral catheter route with special magnification and subtraction views will demonstrate the degree of tumor vascularity and thus exclude the rare possibility of vertebral artery aneurysm as a cause for symptoms. Also, angiography will delineate important vessel relationships, particularly that of the anterior inferior cerebellar artery (AICA) to the tumor.[15, 16, 17] The cerebral angiography should not be performed routinely on every patient with suspected acoustic neuroma. CPA myelography is used



Figure 3 — Cerebellopontine angle myelogram revealing a large globular defect consistent with acoustic neuroma. Mass appears to be extending out from the internal auditory canal.



Figure 4 — (Top): Polytomography of petrous bone illustrating a widened internal auditory canal (arrow), with erosion of bone secondary to an intracanalicular acoustic neuroma. (Bottom): Contralateral normal internal auditory canal.

when the CT scan is negative but where there is still good clinical evidence that a small tumor is present (Figure 3). Thus, routine neurodiagnostic studies performed on patients with suspected acoustic neuromas should include plain skull roentgenograms, hypocycloidal polytomography of the internal auditory canal, and CT scan. Plain skull films should include Stenvers, Townes, and Caldwell's views. In approximately 80% of cases, hypocycloidal polytomography will identify erosion of bone in the internal auditory canal (Figure 4). This combination of plain skull films and hypocycloidal polytomograms will reveal evidence of a tumor too small to be seen on CT scan.[18, 19] The CT scan accurately detects at least 95% of tumors larger than 1.5 cm in diameter (Figure 5).

Operative Technique

The successful removal of an acoustic neuroma is one of the more demanding and technically difficult operative procedures in neurosurgery. It is usually performed with the patient in the semi-sitting position with the head rigidly fixed in a flexed position with a special skull clamp. Respirations are controlled endotracheally, and arterial blood gases are determined frequently. Intraarterial blood pressure and electrocardiograms are constantly monitored, and a central venous pressure (CVP) line is positioned in the right atrium and confirmed with chest x-ray. An esophageal Doppler stethoscope is inserted for identification of potential air emboli and their removal via the CVP line.

A straight paramedian incision is made just medial to the mastoid process and suboccipital bone removed on the side of the tumor. The lateral extent of the bony removal is carried to the medial edge of the lateral and sigmoid venous sinuses in order to achieve maximal tumor exposure. During the lateral bony exposure, mastoid air cells are usually entered. These should be covered with either muscle or fat tissue to minimize postoperative CSF leaks. After opening the dura mater, the lateral aspect of the cerebellum is retracted upward and medially until the internal auditory meatus is exposed. The availability of self-retaining retractors now makes brain retraction quite safe. A high-speed, air-driven drill removes the bone of the posterior portion of the meatus and exposes the contents of the internal canal, i.e., the intracanalicular extension of the tumor, the nervous intermedius, and the internal auditory artery (Figure 6). The neuroma generally arises from the intracanalicular portion of the vestibular nerve which is posteriorly situated in the canal. The cochlear division in the anteroinferior canal is a rare locus.

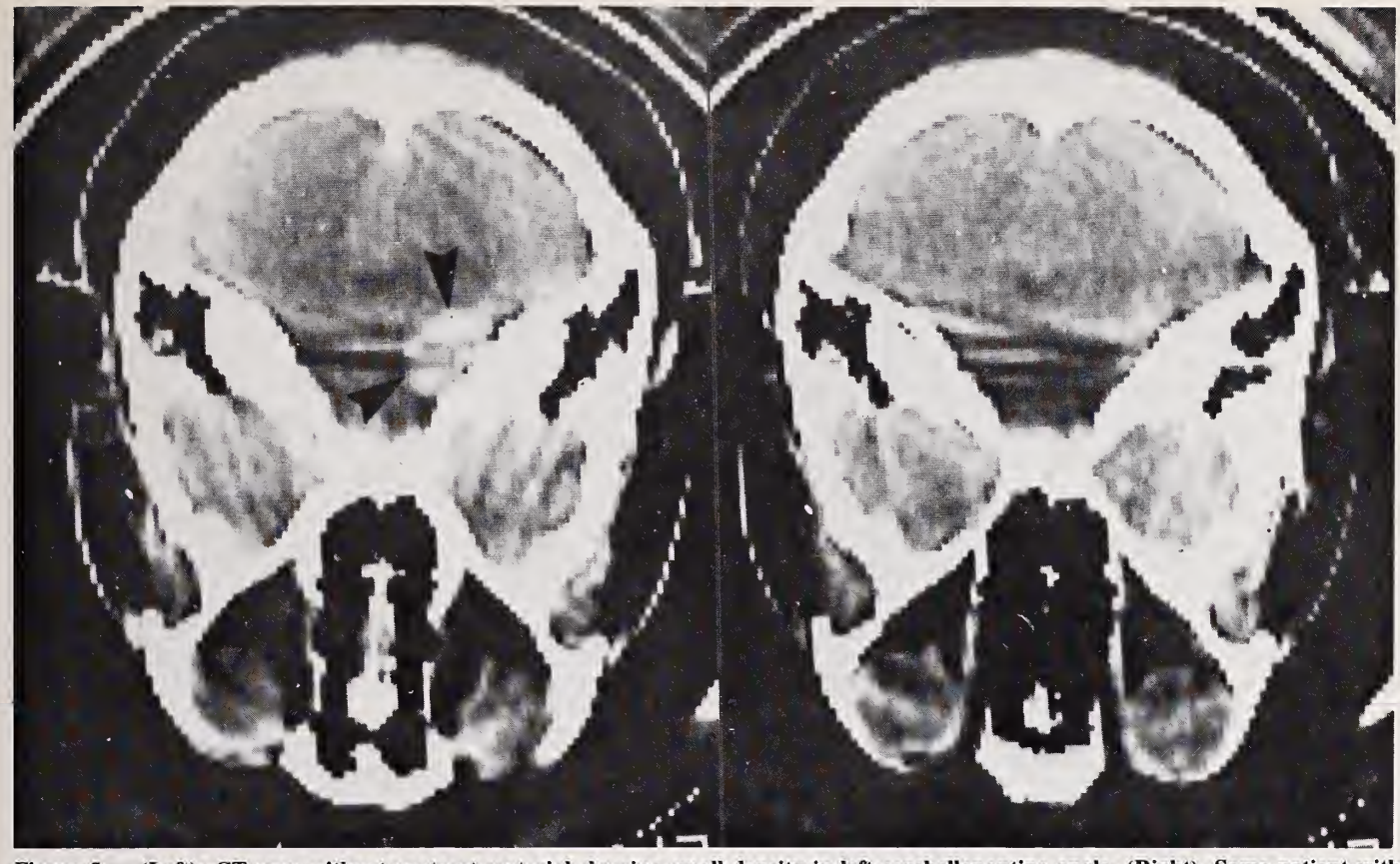


Figure 5 — (Left): CT scan without contrast material showing small density in left cerebellopontine angle. (Right): Same patient with contrast material given delineates an enhanceable left cerebellopontine angle tumor (arrow). Surgery confirmed presence of acoustic neuroma.

The anterosuperiorly located facial nerve is identified and protected throughout the remainder of the operative procedure.

Using microtechniques, the tumor is slowly and carefully dissected away from the nerves, brain, and vascular structures. Care must be exercised in isolating and protecting the anterior inferior cerebellar artery, as serious injury (i.e., thrombosis) to this vessel results in ischemic damage to the pons in 39% of cases. Following resection of the tumor, hemostasis is obtained, the dura is reapproximated, and the remaining wound closed in a routine manner.

Results of Surgery

The goal of therapy in acoustic neuroma surgery is to accomplish a complete resection of the tumor with minimal complications and mortality. With present day techniques this goal can be achieved in the great majority of cases. If the patient is elderly and the tumor large, and if it appears that total resection risks damage to the brain stem or requires excessive operating time, a subtotal intracapsular tumor removal is performed. In the younger patient, it is important to strive for total resection, because an incompletely removed tumor will invariably recur. For younger patients with large tumors we have occasionally performed total removal in two stages because of the long operating time, often 14-16 hours.

There are several recently published series citing results and complications of acoustic neuroma surgery. DiTullio et al.[22] treated 79 patients, with total removal of tumor in 91% of cases, with a mortality rate of 3.7%. Facial motor activity was preserved in 59% of the cases, partially preserved in 29%, and lost in 12%. Table 2 shows that complications and results correlate closely with size of the tumor. The ideal result, i.e., total resection with preservation of facial motor function, was accomplished in 66% of tumors that measured between 2 and 4 cm. All mortalities occurred in the group with tumors greater than 4 cm, and an ideal result was obtained in only 38% of cases. Ojemann et al.[23] reported 46 patients with 48 tumors treated surgically by combined translabyrinthine and suboccipital approaches. Of patients in his series who underwent translabyrithine or middle fossa operation (i.e., patients with small tumors) with total or radical subtotal removal, 14 of 17 (82%) had normal or slightly impaired facial nerve function. With the combined technique for large tumors, it was possible with total or radical subtotal removal of the tumor to preserve normal or satisfactory facial nerve function in 11 out of 14 patients (79%).

The majority of 15 patients in our series presented with large tumors and multiple neurologic problems. In all cases, complete resection of the tumor was accomplished with meticulous efforts to preserve

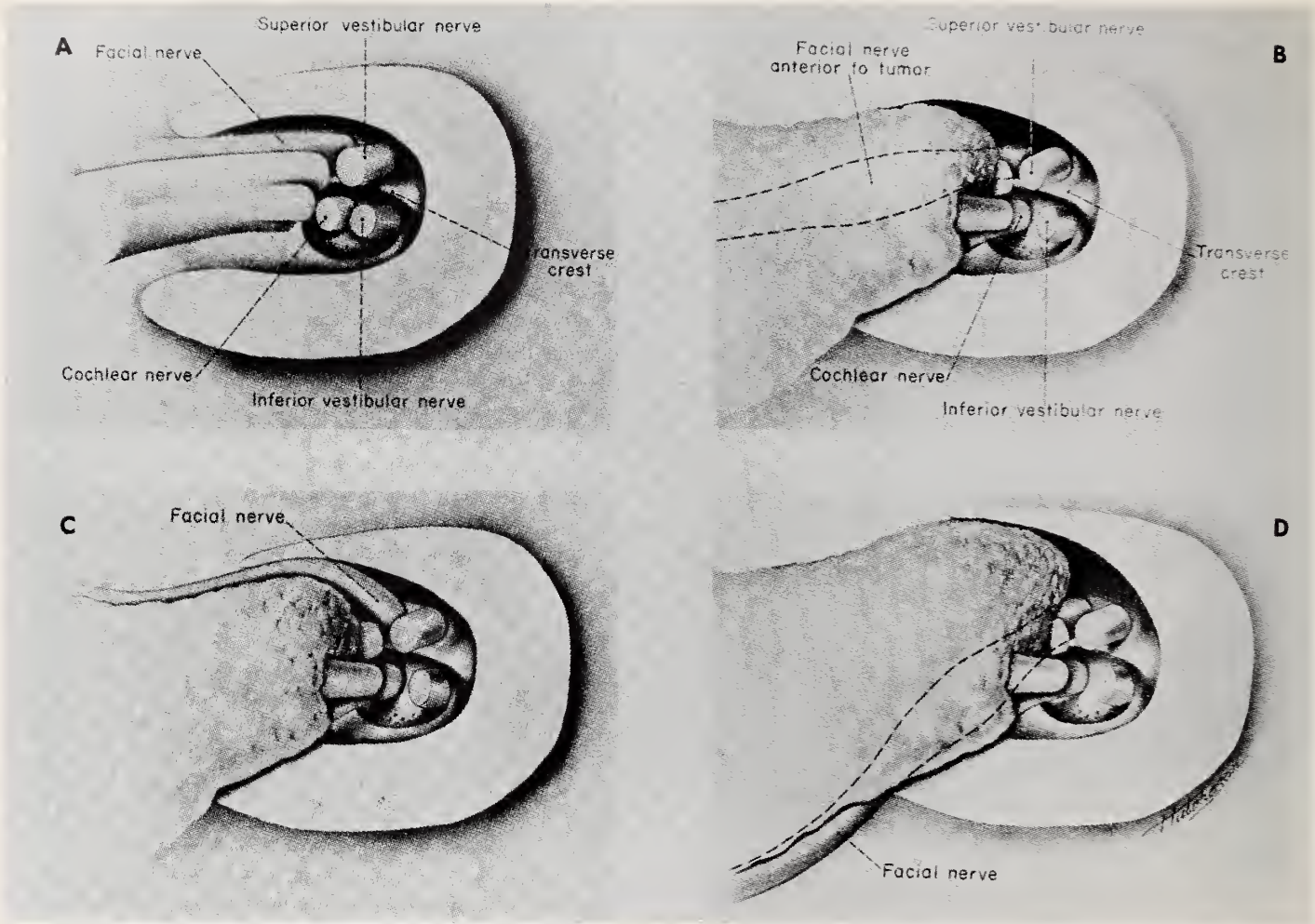


Figure 6 — A: Normal neural relationship. Facial and superior vestibular nerves are above the transverse crest and cochlear and inferior vestibular nerves are below. Facial nerve is seen anterosuperiorly. B: Anterior displacement of facial nerve caused by acoustic neuroma. C: Anterosuperior displacement of the facial nerve caused by an acoustic neuroma. D: Anteroinferior displacement of the facial nerve caused by an acoustic neuroma.[25]

facial nerve function. There were no operative deaths, and facial nerve function was preserved in six patients. The relatively high incidence of facial paralysis in our experience is related to the large size of the tumor; eight of the tumors were larger than 3 cm. Of the nine patients who experienced postoperative facial palsy, the facial nerve was left intact in three cases, and in all three there has been a gradual return of facial nerve function. Most of the other patients have benefitted by hypoglossal to facial nerve anastomosis, regaining some function of their facial musculature. We have had some relatively minor complications, such as transient CSF leaks and local wound care problems, all of which responded to the appropriate therapy.

TABLE 2 — Tumor Size*

Tumor Size	2 cm	2-4 cm	4 cm	Total
Number of cases	6	28	45	79
Percent	7.6	35.4	57	100
Percent of cases with total removal	100	93	89	91
Percent with 7th nerve function				
Intact	100	79	42	59
Partial		14	42	29
Absent		7	16	12
Percent with complications				
CSF leaks		7	13	
Ataxia		7	0	
Hemiplegia			4	
Decreased gag			9	
Hypesthesia V_1			18	
Deaths			6.6	3.7
Ideal results (%)	100	66	38	52

* Source: DiTullio.[22]

Complications

Although most patients do well postoperatively, complications can and do arise. The most common is facial nerve paralysis. The nerve may recover depending on its integrity and regenerative capacity. When a tumor is removed and the nerve left anatomically intact but nonfunctioning, a 6 to 12-month observation period for signs of regeneration should be followed before considering a nerve grafting procedure.[24] If the facial nerve has been severed, a small segment of sural nerve can be used to graft the damaged ends of the nerve. Another and more frequently used option is to anastomose the hypoglossal to the facial nerve just distal to the stylomastoid

foramen using microtechniques. This can be done 2 to 4 weeks postoperatively or later if so indicated.

Air emboli can occur in the sitting position due to the negative cephalic venous pressure. Air that leaves the heart via the pulmonary arteries can create a ventilation perfusion abnormality causing hypoxia. Careful monitoring of blood flow, however, with the esophageal Doppler stethoscope will alert the anesthesiologist to the presence of air which can then be removed via the CVP line. Another complication seen infrequently is a CSF leak which usually ceases spontaneously.

Summary

Acoustic neuromas present with hearing loss, tinnitus, dizziness, or ataxia. They are diagnosed with otologic and vestibular studies, hypocycloidal tomography, CT scan, and CPA myelography. Patients can be successfully treated and cured with surgery. The operation is relatively safe and effective because of improved neuroanesthetic and microsurgical techniques.

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Today, thousands of persons with this disease survive into adulthood.

Adult Cystic Fibrosis: A New Therapeutic Challenge for the Primary Care Physician

WILLIAM F. BRIA, M.D., and WILLIAM R. KENNY, M.D., *Atlanta**

Introduction

THE MANAGEMENT OF cystic fibrosis (CF, Mucoviscidosis), the most common lethal hereditary disease in the United States, has in the past been relegated to the pediatrician and the pediatric pulmonologist almost exclusively. This is undoubtedly because 20 years ago most CF patients died within the first year of life.[1] Ten years ago, few lived beyond the age of 10 years. Today, thousands of persons with CF are surviving into adulthood and require the attention of primary care physicians for their pulmonary and other problems.[2] In this article we will examine the reasons for the prolonged survival of individuals with CF as well as discuss the pathogenesis, diagnosis and treatment of this multisystemic disease.

Description

Cystic fibrosis, first described in 1936 by Fanconi, is a hereditary disease transmitted as a Mendelian recessive trait, occurring once every 1800 live white births. The prevalence of carriers in the general population is 5%, but somewhat less in the black population. Despite much research in the area, the basic defect in CF remains unknown, and hence the disease is without a cure. The inborn error leads to two separate consequences: the sweat electrolyte defect and an abnormality of mucous secretions.

The diagnosis of CF usually includes the triad of 1) pancreatic insufficiency, 2) sweat chlorides greater than 60 meq/L, and 3) chronic lung disease. However, less common presentations of this disease include cirrhosis, infertility, heat prostration, diabetes, and seizures. These uncommon manifestations of CF may be the only clues to the disease in the adult cystic; however, family history is often helpful.[3]

Pathogenesis

The pathogenesis of the pulmonary involvement in CF invariably involves a defective "muco-ciliary escalator" mechanism and the production of abnormally viscous mucous secretions.[4] Usually, there is a history of respiratory infection with the development of copious bronchial secretions which are ineffectively removed. Some component of bronchial obstruction develops even when antimicrobial therapy is employed. This cycle is repeated with each new infection (chronic bronchopneumonia) and irreversible damage (obstructive emphysema) eventually occurs. It is interesting to note that patients with CF do not have altered humoral or cellular immunity.[4] Therefore, the recurrent respiratory tract infections must be attributed to factors other than immunoincompetence, such as abnormal secretions and clearing mechanisms. Death results from various complications including bronchiectasis, cor pulmonale, hemoptysis, pneumothorax, or pulmonary insufficiency.

It is generally agreed that the major prognostic factor in CF is the severity of the pulmonary involvement. This fact was supported by a recent

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long-term clinical study by Stern et al.[5] who followed a group of young CF patients for 13 years. By means of a clinical scoring system,[6] they divided their patients into Group 1, with minimal pulmonary involvement, and Group 2, with moderate to severe pulmonary involvement after 1 year of treatment. Of the 45 patients in Group 1, only one died during the study, and none were disabled. In contrast, of the other 50 patients in Group 2, 26 died during the study. The importance of pulmonary involvement in CF is further supported by the fact that the degree of malnutrition and wasting in patients with CF is more closely related to the degree of severity of pulmonary disease and its relapses than with pancreatic insufficiency.[2]

The uncommon manifestations of CF include diabetes mellitus, cirrhosis, and infertility. Diabetes mellitus in CF is believed to be secondary to disruption of the architecture of the islets of Langerhans by increasing fibrosis.[7] The disorganization of the islets may be a much slower process than the fibrous replacement of the exocrine parenchyma of the pancreas. This may account for the development of diabetes late in the course of CF. Clinically, diabetes in CF is usually mild, being easily controlled with small doses of insulin.[2] Hepatic involvement occurs in about 2% of CF patients and results in focal biliary cirrhosis which can proceed to portal hypertension and its complications (variceal bleeding, hypersplenism, hepatic coma).[8]

It has been reported that about 95% of males with cystic fibrosis are infertile due to low sperm counts or aspermia.[9] The cause is incomplete development of the mesonephric derivatives (vas deferens, seminal vesicles, and epididymides).

Therapy

To successfully treat CF, the primary care physician should 1) enlist the aid of specialists and allied health professionals where needed, 2) individualize therapy for this protean disease and, 3) always seek the highest quality of life and activity for his patient.[4]

Since lung disease is so important prognostically in CF, efforts to treat this aspect of the disease can yield the highest benefits. Immunizations (DPT, measles, influenza) are essential for CF patients to interrupt the cycle of chronic pulmonary infection and damage. The value of pneumococcal vaccine in these patients is not yet clear.

Rational antimicrobial therapy in CF involves the usual culture procedures with a few special considerations. *Staphylococcus aureus* is the most common organism found in the untreated patient with CF while *Pseudomonas aeruginosa* is most common after initiation of treatment. Indeed, it appears that CF patients have an unusual susceptibility to Pseudomonas infections.[10] Antibiotic therapy is clearly indicated not only to treat acute infections but also to retard the progression of the lung disease by preventing permanent bronchial wall damage. The role of prophylactic antibiotics given by pill or inhalation is somewhat controversial at the present time.[2, 4]

Physical methods to help clear pulmonary secretions (postural drainage, clapping, etc.) are very effective when performed routinely and correctly by the patient and his family. In certain special circumstances, fiberoptic bronchoscope lavage of CF patients has proved quite effective.[11] Liquefication of viscous secretions by nebulization, with or without mucolytic agents (e.g., Mucomyst®) and bronchodilators has also proven of value. However, intermittent positive pressure breathing machines (IPPB) are contraindicated in CF due to exacerbation of air trapping.

Dietary restriction in CF depends on fecal content and degree of pancreatic exocrine insufficiency. Pancreatic enzymes, fat restriction, vitamins, and salt replacement must all be utilized in concert with the patient's individual needs.

Surgery has a limited role in the treatment of CF. Meconium ileus (rare in the adult patient) is an obvious surgical problem.[12] Porto-systemic bypass for those uncommon cases of cirrhosis with portal hypertension in CF has proven of value in some studies.[8] However, because of the diffuse nature of the lesion, surgical therapy of pulmonary disease in CF is almost never indicated (exception, exsanguinating hemoptysis).

Psychiatric counseling is a facet of the treatment of CF that probably becomes more important as the patient grows older. In long-term studies of adult CF patients, two major maladaptive mechanisms were identified: 1) familial over-protectiveness, and 2) denial.[1] Patients and their families often need professional help to aid them in coping with this chronic disease.

Conclusion

The reasons for the improved prognosis in CF are multiple: improved antibiotic therapy, early diagnosis, specialized care centers, and aggressive treatment regimens. This presents the primary care physician with a new and challenging patient population, requiring the coordinated effort of the health care team, including specialists, nurses, therapists, etc., to achieve effective therapy for this truly multisystemic disease.

Acknowledgment

The authors thank Mary Hamacher for invaluable assistance.

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Clinical Oncology Association of Georgia— Educational Program for the 1979-1980 Academic Year

The Clinical Oncology Association of Georgia is a statewide organization whose purpose is to provide a forum for continuing education in the field of oncology. The organization has approximately 150 members. Membership is available to any interested physician, nurse, or other allied health personnel. Three categories of membership exist as follows: Active members who have voting privileges and who have a major continuing interest in the field of oncology; associate members who are persons with interest in selected fields of cancer diagnosis and treatment; and affiliate members who are nurses and allied health personnel with a major interest in the field of oncology. The first year's program was quite successful, with excellent presentations by distinguished speakers from around the country. Support for the Clinical Oncology Association of Georgia is drawn entirely from dues paid by the membership. These dues are paid on an annual basis and are as follows: $50.00 — active members; $25.00 — associate members; and $10.00 — affiliate members. Payment of dues for the 1979-1980 academic year is now being requested.

Planning for the educational program for the upcoming academic year is nearly complete. Programs scheduled thus far include the following:

Dr. Bernard Levin — Wednesday, November 7, 1979 — Director of the GI Oncology Unit at the University of Chicago — "Carcinoma of the Colon and Pancreas."

Dr. William Enneking — Wednesday, December 5, 1979 — "Management of Bony Sarcomas."

Dr. Rodney Million — Wednesday, February 6, 1979 — "Skin Cancer."

Additional presentations are planned on the current management of genitourinary malignancy and surgical problems in the management of pulmonary neoplasms. We feel the educational opportunities provided by this program are outstanding. Response to previous seminars has been quite good by all attending. These meetings are held on Wednesday evenings at an Atlanta area restaurant and include a brief social hour and dinner, followed by a presentation of the evening's topic.

We look forward to a productive and educational 1979-1980 academic year. We encourage all previous Clinical Oncology Association of Georgia members to renew their membership and enlist the support of additional persons throughout the state with an interest in the diagnosis and treatment of malignant disease.

(Submitted by J. L. Lokey, M.D., President; Stan Winokur, M.D., President-elect; and William Whaley, M.D., Secretary-Treasurer, Clinical Oncology Association of Georgia.)

Vital Records Service to Implement Revised Birth and Fetal Death Documents

On Jan. 1, 1980, the Georgia Department of Human Resources (DHR), Vital Records Service, will begin using a new Certificate of Live Birth, Report of Induced Termination of Pregnancy, and Report of Spontaneous Abortion or Stillbirth. These documents were revised to rectify problems DHR has had with document completion, legibility, coding, and data entry. The revised documents were also changed to reflect national trends concerning data variables used in planning state and community health programs.

County vital records registrars and hospital staff will be notified concerning the location and time where instruction for the completion of fetal death documents will be held. Training will begin in September and continue through December.

All questions concerning these revised documents should be directed to Michael R. Lavoie, Director, Vital Records Service, Room 217-H, 47 Trinity Avenue, S.W., Atlanta, Georgia 30334.



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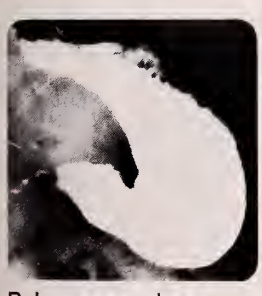
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†See Warnings, Precautions and Adverse Reactions.

See following page for prescribing information.

Reference:
King, J.C. and Starkman, N.M.: Evaluation of an antispasmodic. Double-blind evaluation to control gastrointestinal spasms occurring during radiographic examination. A preliminary report. Western Med. 5:356-358, 1964.

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For use in the treatment of infant colic (syrup).

Final classification of the less-than-effective indications requires further investigation.

CONTRAINDICATIONS: Obstructive uropathy (for example, bladder neck obstruction due to prostatic hypertrophy); obstructive disease of the gastrointestinal tract (as in achalasia, pyloroduodenal stenosis); paralytic ileus, intestinal atony of the elderly or debilitated patient; unstable cardiovascular status in acute hemorrhage; severe ulcerative colitis; toxic megacolon complicating ulcerative colitis; myasthenia gravis. WARNINGS: In the presence of a high environmental temperature, heat prostration can occur with drug use (fever and heat stroke due to decreased sweating). Oiarrhea may be an early symptom of incomplete intestinal obstruction, especially in patients with ileostomy or colostomy. In this instance treatment with this drug would be inappropriate and possibly harmful. Bentyl may produce drowsiness or blurred vision. In this event, the patient should be warned not to engage in activities requiring mental alertness such as operating a motor vehicle or other machinery or perform hazardous work while taking this drug. PRECAUTIONS: Although studies have failed to demonstrate adverse effects of dicyclomine hydrochloride in glaucoma or in patients with prostatic hypertrophy, it should be prescribed with caution in patients known to have or suspected of having glaucoma or prostatic hypertrophy. Use with caution in patients with: Autonomic neuropathy. Hepatic or renal disease. Ulcerative colitis. Large doses may suppress intestinal motility to the point of producing a paralytic ileus and the use of this drug may precipitate or aggravate the serious complication of toxic megacolon. Hyperthyroidism, coronary heart disease, congestive heart failure, cardiac arrhythmias, and hypertension. Hiatal hernia associated with reflux esophagitis since anticholinergic drugs may aggravate this condition.

Do not rely on the use of the drug in the presence of complication of biliary tract disease. Investigate any tachycardia before giving anticholinergic (atropine-like) drugs since they may increase the heart rate. With overdosage, a curare-like action may occur. ADVERSE REACTIONS: Anticholinergics/antispasmodics produce certain effects which may be physiologic or toxic depending upon the individual patient's response. The physician must delineate these. Adverse reactions may include xerostomia; urinary hesitancy and retention; blurred vision and tachycardia; palpitations; mydriasis; cycloplegia; increased ocular tension; loss of taste; headache; nervousness; drowsiness; weakness; dizziness; insomnia; nausea; vomiting; impotence; suppression of lactation; constipation; bloated feeling; severe allergic reaction or drug idiosyncrasies including anaphylaxis; urticaria and other dermal manifestations; some degree of mental confusion and/or excitement, especially in elderly persons; and decreased sweating. With the injectable form there may be a temporary sensation of lightheadedness and occasionally local irritation. DOSAGE AND AOMINISTRATION: Dosage must be adjusted to individual patient's needs.

Usual Dosage: Bentyl 10 mg. capsule and syrup: *Adults:* 1 or 2 capsules or teaspoonfuls syrup three or four times daily. *Children:* 1 capsule or teaspoonful syrup three or four times daily. *Infants:* ½ teaspoonful syrup three or four times daily. (May be diluted with equal volume of water.) Bentyl 20 mg.: *Adults:* 1 tablet three or four times daily. Bentyl Injection: *Adults:* 2 ml. (20 mg.) every four to six hours intramuscularly only. NOT FOR INTRAVENOUS USE. MANAGEMENT OF OVERDOSE: The signs and symptoms of overdose are headache, nausea, vomiting, blurred vision, dilated pupils, hot, dry skin, dizziness, dryness of the mouth, difficulty in swallowing, CNS stimulation. Treatment should consist of gastric lavage, emetics, and activated charcoal. Barbiturates may be used either orally or intramuscularly for sedation but they should not be used if Bentyl with Phenobarbital has been ingested. If indicated, parenteral cholinergic agents such as Urecholine® (bethanecol chloride USP) should be used.

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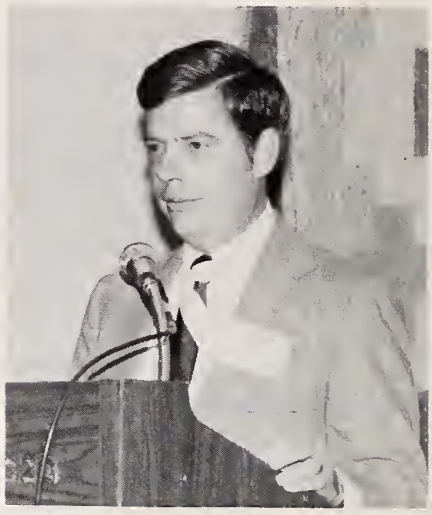
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David Satcher, M.D., Chairman, Department of Community Medicine, Morehouse School of Medicine told how that school was training primary care physicians in cost awareness.

John Bawling, Associate Administrator, Kennestone Hospital, Marietta, GA, spoke on his hospital's efforts to reduce costs.





Terrence Kuske, M.D., Professor of Medicine and Assistant Dean of Curriculum from the Medical College of Georgia, described that school's new curriculum relating to cost awareness.



Leon Zucker, from Jackson Memorial Hospital in Miami, Florida, related that hospital's "success story" re cost effective innovations.



John Tillotson, M.D., from Excelsior, Minnesota, spoke about stimulating competition among medical care providers — particularly via Health Maintenance Organizations.



Tom Kinser (L), Vice-President, Health Affairs, Blue Cross/Blue Shield, Atlanta, and David Schaeffer, representing the American Hospital Association from Chicago, listen to the morning speakers.

MAG's Second Annual Cost Awareness Conference

editorial
editorial
editorial



H. Duane Blair, M.D. (L), Chairman of MAG's Committee on Cost Awareness, and Harrison L. Rogers Jr., M.D., Vice-Speaker of the AMA House of Delegates.

Cost Awareness — An Accomplished Fact

COST AWARENESS is an accomplished fact. Such was the consensus of those attending the Medical Association of Georgia's (MAG) second annual meeting on the problems relating to the cost of health care held at the Peachtree Plaza Hotel in Atlanta. Dr. H. Duane Blair, Chairman of MAG's Committee on Cost Awareness, opened the meeting held Aug. 25, 1979, with a reaffirmation of the importance of cost awareness and cost restraint. The panel of speakers represented organized medicine, the American Hospital Association, health insurors, hospital administrators, and staff to congressional committees dealing with health.

An innovation this year was the inclusion of medical school representatives from both the Medical College of Georgia and Morehouse. Such innovation was possible this year because medical educators in general and these two schools in particular have joined the national effort to see that cost effective medical care is the goal of every medical student and resident in their schools. The Medical College of Georgia has received a large grant from Blue Cross and Blue Shield of Columbus to fund a major effort which initially will effect cost awareness of the students, residents, and faculty; then, subsequently, subject the results of this effort to critical analysis. It was obvious to the audience that regardless of the results of the analysis the entire physician population of Augusta will shortly be ardent supporters of cost effective medical care. The enthusiasm of Dr. Terrence Kuske from the Department of Medicine was obvious, and the conference participants applauded his efforts (and hopefully will emulate them!).

Reports from organized medicine, hospital administrators, and health insurors this year reflected the additional time and effort that has been put into this ongoing task. Instead of plans and projections which had been the rule in 1978, at this meeting the conference heard success stories from all as plans were put into operation. Utilization review of the Atlanta Blue Cross/Shield subscribers needing hospitalization in the past year has been followed by a 10% reduction in utilization for the plan which had a high rate of utilization as a major problem prior to initiation of the cost effort.

Physicians and hospital administrators participating in the Voluntary Effort were reported to have had a major impact on hospital cost containment. The 1978 success of this effort was given much of the credit for defeat of the Carter Administration's onerous Cost Containment Act. The Congress did not feel that the health care "industry" should be singled out for price controls, when it was the only industry in our nation with a successful voluntary program of cost restraint. Having made the "easy" cuts during 1978, it was pointed out that future good results would be more difficult to achieve. Mr. John Bowling of Kennestone Hospital in Marietta, however, assured the conference that with continued cooperation between medical staff and administration, such results are possible. His organization (American Hospital Association) is focusing its efforts next year on restraints in increases in hospital personnel. With increased productivity he feels that he will be able to serve our patients better with the same number of employees. This goal differs decisively from the situation in which growing numbers of administrative personnel seen in countries with federal health systems, as well as with the growing number of administrative personnel in our federal bureaucracy, add greatly to the cost of medical care.

Finally, specific areas of responsibility for the practicing physician were highlighted:

1. A renewed effort at restraint in physician fee increases required to meet inflated office budgets was supported.
2. A continued critical appraisal of each hospital admission to be absolutely certain that the required service could not have been furnished as an outpatient.
3. Continuous monitoring of the diagnostic and therapeutic measures ordered on our hospitalized patients to be sure that each is necessary, not repetitive and in addition, is cost effective.
4. Frank and timely discussions with our patients and their families on the advisability of "heroic" measures of life support in the face of hopeless situations.
5. Early discharge planning by the physician and patient as well as his family will make the transition to outpatient care as smooth as possible.
6. Efficient operation of our offices, with coordination of consultants and their services, along with prompt sharing of all diagnostic studies and historical data.

The meeting closed on an optimistic note — that cost awareness was in many areas an accomplished fact, and that cost effective medical care was sure to follow the joint efforts of all those groups involved in the meeting. Emphasis was given to the value of including the general public in all our programs and the participants subsequently returned to their homes filled with the fervor of a Revival Meeting!

Harrison L. Rogers, M.D.
Vice-Speaker
AMA House of Delegates

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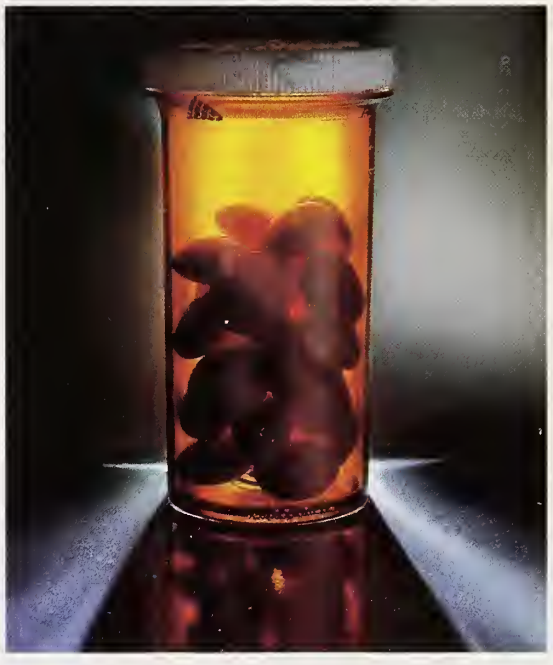
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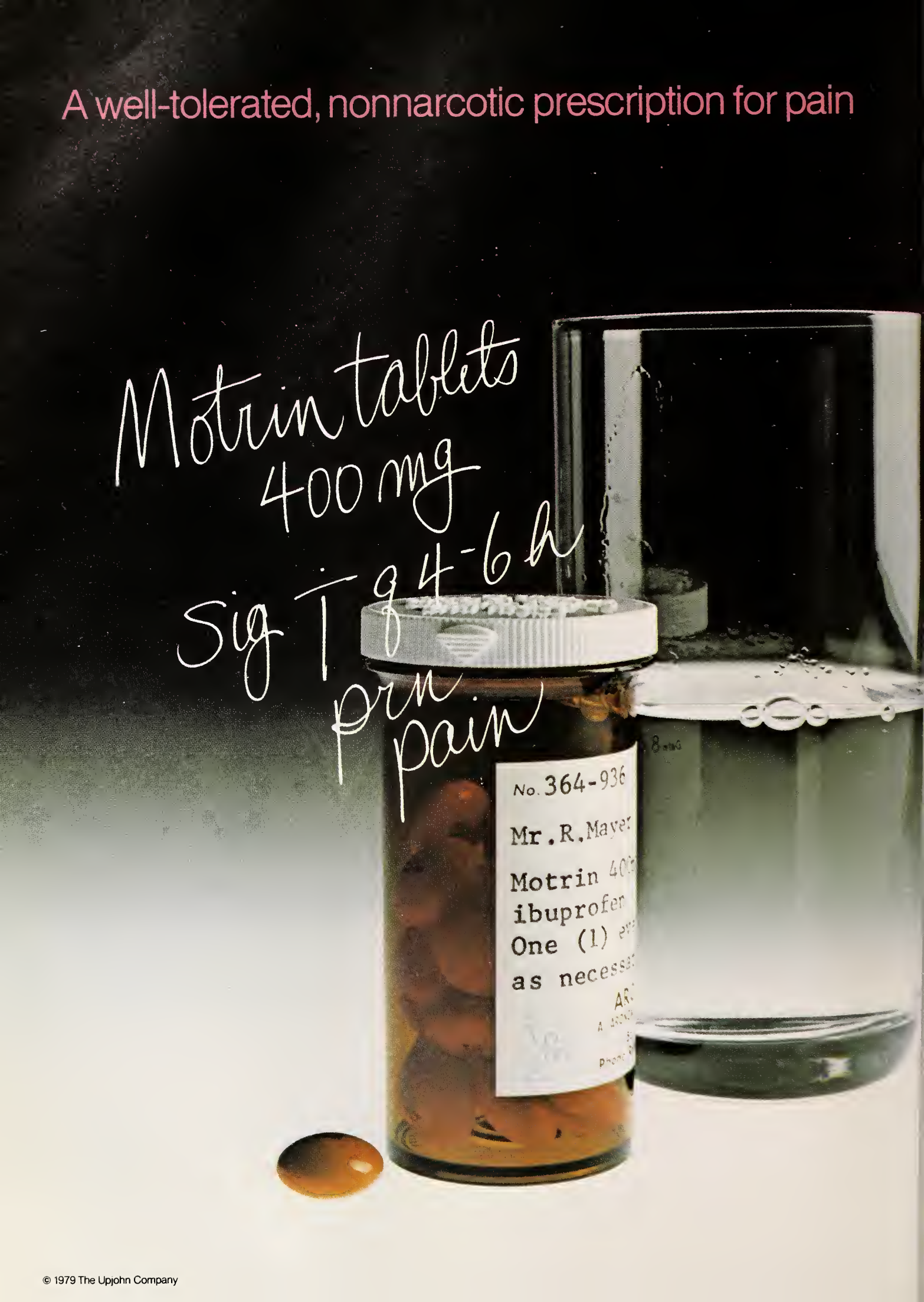


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Statistical significance		$p<0.02$	$p<0.01$	$p<0.05$	$p<0.02$	$p<0.002$

*0 = No relief 1 = Partial relief 2 = Complete relief

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Warnings: Anaphylactoid reactions have occurred in patients with aspirin hypersensitivity (see CONTRAINDICATIONS).

Peptic ulceration and gastrointestinal bleeding, sometimes severe, have been reported. Ulceration, perforation, and bleeding may end fatally. An association has not been established. Motrin should be given under close supervision to patients with a history of upper gastrointestinal tract disease, only after consulting ADVERSE REACTIONS.

In patients with active peptic ulcer and active rheumatoid arthritis, nonulcerogenic drugs, such as gold, should be tried. If Motrin must be given, the patient should be under close supervision for signs of ulcer perforation or gastrointestinal bleeding.

Precautions: Blurred and/or diminished vision, scotomata, and/or changes in color vision have been reported. If these develop, discontinue Motrin and the patient should have an ophthalmologic examination, including central visual fields.

Fluid retention and edema have been associated with Motrin; use with caution in patients with a history of cardiac decompensation

Motrin can inhibit platelet aggregation and prolong bleeding time. Use with caution in persons with intrinsic coagulation defects and those on anticoagulant therapy.

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To avoid exacerbation of disease or adrenal insufficiency, patients on prolonged corticosteroid therapy should have therapy tapered slowly when Motrin is added.

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Incidence greater than 1%

Gastrointestinal: The most frequent type of adverse reaction occurring with Motrin is gastrointestinal (4% to 16%). This includes nausea,* epigastric pain,* heartburn,* diarrhea, abdominal distress, nausea and vomiting, indigestion, constipation, abdominal cramps or pain, fullness of the GI tract (bloating and flatulence). **Central Nervous System:** Dizziness,* headache, nervousness. **Dermatologic:** Rash* (including maculopapular type), pruritus. **Special Senses:** Tinnitus. **Metabolic:** Decreased appetite, edema, fluid retention. Fluid retention generally responds promptly to drug discontinuation (see PRECAUTIONS).

*Incidence 3% to 9%.

Incidence less than 1 in 100

Gastrointestinal: Upper GI ulcer with bleeding and/or perforation, hemorrhage, melena. **Central Nervous System:** Depression, insomnia. **Dermatologic:** Vesiculobullous eruptions, urticaria, erythema multiforme. **Cardiovascular:** Congestive heart failure in patients with marginal cardiac function, elevated blood pressure. **Special Senses:** Amblyopia (see PRECAUTIONS). **Hematologic:** Leukopenia, decreased hemoglobin and hematocrit.

Causal relationship unknown

Gastrointestinal: Hepatitis, jaundice, abnormal liver function. **Central Nervous System:** Paresthesias, hallucinations, dream abnormalities. **Dermatologic:** Alopecia, Stevens-Johnson syndrome. **Special Senses:** Conjunctivitis, diplopia, optic neuritis. **Hematologic:** Hemolytic anemia, thrombocytopenia, granulocytopenia, bleeding episodes. **Allergic:** Fever, serum sickness, lupus erythematosus syndrome. **Endocrine:** Gynecomastia, hypoglycemia. **Cardiovascular:** Arrhythmias. **Renal:** Decreased creatinine clearance, polyuria, azotemia.

Overdosage: In cases of acute overdosage, the stomach should be emptied. The drug is acidic and excreted in the urine, so alkaline diuresis may be beneficial.

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Do not exceed 2400 mg per day.

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J9AR13

Direct Dispensing of Prescription and Non-prescription Drugs by Physicians to Patients Under Federal and State Law

ROBERT N. BERG, *Atlanta**

SEVERAL MONTHS AGO, the Legal Page of the *Journal* dealt with the topic of the regulation of prescription drugs under federal and state law,[1] primarily from the perspective of the need for and nature and content of written and oral prescriptions. Since that time, we have on several occasions been asked to look into various other aspects in connection with the regulation of prescription drugs and medications, one of the most interesting and complex of which is the subject of this month's Legal Page: What must a physician do in order to comply with the federal and state laws when directly dispensing drugs or medications to his or her patients?

In general, the dispensing of drugs under Georgia law is governed by Chapter 79A-4 (dealing with pharmacists) and Chapter 79A-5 (dealing with pharmacies) of the Georgia Code. Pursuant to these Chapters, persons other than pharmacists are prohibited from either "dispensing" or "vending at retail" any medicines, drugs or poisons.[2] Since the term "dispensing" is defined as including "the issu(ance) of one or more doses of medication . . . for subsequent use by a patient,"[3] the practice by physicians of either giving away drug samples or selling medications or drugs directly to patients would appear, at first blush, to violate the prohibitions described above. However, "practitioners of the healing arts," (defined as including physicians, dentists, veterinarians, and other persons licensed to use, mix, prepare, dispense, prescribe, and administer drugs in connection with medical treatment[4]) are expressly exempted from these general proscriptions when "prescribing or putting up their own prescriptions and dispensing drugs or medicines."[5] Consequently, it is necessary to look beyond the general requirements of the Georgia laws which regulate pharmacists and pharmacies, and look at the specific requirements under Georgia law with respect to different types of drugs.

Dangerous Drugs

The prescribing, ordering, and dispensing of "dangerous drugs" are governed in Georgia by the "Dangerous Drug Act."[6] Pursuant to this Act, a "dangerous drug" is defined as either any drug which may be dispensed only upon prescription under the "Federal Food, Drug, and Cosmetic Act," or any drug declared by the State Drug Inspector to be a "dangerous drug."[7] Examples of the types of drugs covered by this definition would range from narcotic drugs, such as Paregoric, to cough preparations containing the combination of codeine and pheniramine maleate or any of its salts.[8]

Under the Dangerous Drug Act, physicians are authorized to possess, sell, give away, barter, exchange, dispense, or distribute dangerous drugs only to the extent that they satisfy certain requisites with respect to the prescribing and labeling of

* Prepared at the request of the Medical Association of Georgia. Mr. Berg is an associate in the firm of Powell, Goldstein, Frazer & Murphy, General Counsel to the Association, 1100 C & S National Bank Building, Atlanta, GA 30303.

these drugs. As for prescriptions, the physician must provide the name and address of the patient, together with complete directions for administration of the drug.[9] Moreover, if the physician directly dispenses the drug to the patient, the physician must place the drug in a suitable container and affix an appropriate label with the name of the patient, the name and address of the physician prescribing the drug, the expiration date, if any, of the drug, and the date of the prescription.[10]

The failure to comply with these provisions is punishable under Georgia law as a misdemeanor.[11] Thus, the physician who fails to place a dangerous drug in a suitable container when dispensing that drug directly to a patient, or who dispenses the drug in an improperly labeled container, could face criminal punishment in the nature of a fine of up to $1,000, or imprisonment of up to one year, or both.[12]

Controlled Substances

In addition to the Dangerous Drug Act, the direct dispensing of drugs from physician to patient is also regulated in Georgia under the "Georgia Controlled Substances Act."[13] Pursuant to this Act, no person other than a licensed pharmacist is authorized to dispense[14] a controlled substance (any drug listed on Schedules I-V, as established by the Board of Pharmacy).[1] An exception to this broad prohibition exists, however, in that registered practitioners (physicians, dentists, or veterinarians) are permitted to dispense controlled substances to the extent authorized in their registration.[15]

As to the registration requirements, persons licensed as physicians, dentists, or veterinarians are exempted from the registration requirements at the state level. This is only half the story, however, in that controlled substances are also regulated at the federal level pursuant to the federal "Controlled Substances Act" (the "Federal Act"),[16] and this Act mandates that every person who dispenses controlled substances must obtain an annual registration. Consequently, the physician who directly dispenses controlled substances to his or her patients can lawfully do so only if he or she is registered to so dispense under the Federal Act.

In addition to registering, the physician who directly dispenses controlled substances to his or her patients is also subject to the myriad inventory, recording, and reporting requirements of the Federal Act.[17] For example, the physician must take a physical inventory every 2 years, maintaining appropriate records thereof. The physician must also keep accurate records of all controlled substances received and disposed of, including the name of the drug, quantity, strength, form, number of units, and date.[18]

As for the specific rules governing the packaging and labeling of controlled substances, the regulations promulgated under the Federal Act expressly exclude from their coverage practitioners who dispense controlled substances in the course of their professional practice.[19] Moreover, the Georgia Act does not contain any express requirements governing the packaging and labeling of controlled substances by practitioners dispensing directly. However, even though there appears to be little direct authority for doing so, the legislative agencies at both the federal and the state levels charged with enforcing the laws and regulations dealing with controlled substances interpret these laws and regulations as imposing the same standards as to the packaging and labeling of controlled substances as is required with respect to the packaging and labeling of dangerous drugs. Therefore, it would be a good idea for any physician directly dispensing controlled substances to his or her patients to do so in accordance with the minimum standards described above with respect to dangerous drugs — in a "suitable container" with an "appropriate" label.

Drugs and Cosmetics

Finally, the direct dispensing of drugs and medications by a physician is also governed to an extent by the Georgia Drug and Cosmetic Act,[20] which in general deals with the adulteration and misbranding of drugs and cosmetics and which is specifically declared to be "cumulative and supplemental to any and all existing laws relating to the subject-matter (sic) of drugs."[21] Pursuant to this Act, a

prescription drug dispensed by a practitioner may be deemed to be misbranded unless the drug bears a label containing the name and address of the dispensing physician, the serial number and date of the prescription, the name of the patient and, if appropriate, directions for use and cautionary statements.[22]

Like violations of the Dangerous Drug Act, violations of the Drug and Cosmetic Act constitute misdemeanors, with the possibility of either fines or imprisonment, or both.[23]

Conclusion

There is no simple answer to the question of what steps a physician must take in order to comply with the laws whenever he or she directly dispenses drugs or medicines to patients. This complexity is principally due to the fact that the direct dispensing of drugs and medications by physicians to patients is governed at both the federal and the state levels by a patchwork of laws and regulations which are interpreted by a number of different legislative agencies. For example, if the physician is dispensing a dangerous drug, then he or she must abide by the rules as set out in the Georgia Dangerous Drug Act. If the physician is dispensing a controlled substance (which may or may not also be a dangerous drug), then he or she must be aware of the registration and reporting requirements of both the Georgia and the Federal Controlled Substances Act. Additionally, to the extent that the physician is repackaging and relabeling the drugs, he or she must satisfy the requirements of the Georgia and federal statutes governing the adulteration and misbranding of drugs and cosmetics. Consequently, the physician who directly dispenses drugs and medications to his or her patients would be well-advised to know which drugs he or she is dealing with and if and to what extent he or she is authorized to directly dispense these drugs. The physician who directly dispenses drugs or medicines should use an extra ounce of caution to ensure that those drugs or medicines are properly packaged and labeled.

Notes

1. Berg RN: Prescription drugs under federal and state law. JMAG 68(6):486, 1979
2. *Ga. Code Ann.* §§79A-410(a),(b) and 79A-517(a)
3. *Ga. Code Ann.* §79A-102(e)
4. *Ga. Code Ann.* §79A-102(q)
5. *Ga. Code Ann.* §§79A-410(c) and 79A-517(b)
6. *Ga. Code Ann.* §79A-701 *et seq.*
7. Pursuant to *Ga. Code Ann.* §79A-306, the State Drug Inspector is required to compile, publish, update, and distribute a pamphlet listing all narcotics and dangerous drugs and describing these narcotics and drugs in terms of "taste, smell, physical features, and feel." This pamphlet can be obtained upon request by "interested citizens" for a reasonable fee.
8. Rules of the Georgia State Board of Pharmacy, Section 480-8-.01
9. *Ga. Code Ann.* §79A-706
10. *Ga. Code Ann.* §§79A-102(e) and 79A-705
11. *Ga. Code Ann.* §79A-9909
12. *Ga. Code Ann.* §27-2506(a)
13. *Ga. Code Ann.* §79A-801 *et seq.*
14. Under the Controlled Substances Act, the term "dispense" is defined as meaning "to deliver a controlled substance to an ultimate user . . . by or pursuant to the lawful order of a practitioner, including the prescribing, administering, packaging, labeling, or compounding necessary to prepare the substance for that delivery. . . ." *Ga. Code Ann.* §79A-802(i).
15. *Ga. Code Ann.* §79A-820(g)
16. 21 U.S.C. §801 *et seq.*
17. Pursuant to *Ga. Code Ann.* §79A-818, "Persons registered to manufacture, distribute, or dispense controlled substances under this Chapter [Chapter 79A-8] shall keep a complete and accurate record of all controlled substances on hand, received, manufactured, sold, dispensed or otherwise disposed of, and shall maintain such records and inventories in conformance with the record-keeping and inventory requirements of Federal law and with any rules issued by the Board of Pharmacy."
18. 21 U.S.C. §827; 21 C.F.R. §1304.01 *et seq.*
19. 21 C.F.R. §1302.02(d)
20. *Ga. Code Ann.* §79A-1001 *et seq.*
21. *Ga. Code Ann.* §79A-1018
22. *Ga. Code Ann.* §79A-1009(1)
23. In addition to the Georgia Food and Drug Act, there is also a federal statute dealing with the adulteration and misbranding of drugs and cosmetics. This statute, known as the *Federal Food, Drug and Cosmetic Act,* 21 U.S.C. §301 *et seq.*, is principally the same as the Georgia Act. See, *e.g.* 21 U.S.C. §§352, 353 and 360.



The Fall of the House of Medicine

ONCE UPON A TIME and long ago on this side of the sea was a wise man named Medicine. He lived in a large beautiful house, was well-respected, and went about the country helping the sick and the poor.

Medicine had many sons. Some of their names were: Internal, Surgical, Hospital, Reconstructive, Orthopedic, Neurologic, HMO, Osteopathic, FMG, EENT, Black, AMA, Radiology, Emergency, Nuclear, White, Para, etc. He taught his sons unity, integrity, honesty and, above all, that their patients came first.

For many years the sons adhered to the teachings and philosophy of their father, Medicine. They prospered, and the people of the land had the best medical care in the world.

In time, however, some of the sons became greedy, jealous, non-caring, and occasionally dishonest. This disturbed Father Medicine, and he told his sons that unless they adhered to their father's earlier moral code, they would become weak and ineffectual.

In the meantime, there was a mean old dragon named Government that had been quiescent but now saw his chance to take over the country and rule the House of Medicine. The old dragon was shrewd and planted unrest in the minds of the patients. With promises and gifts, old Government was able to promote fights and even lawsuits among the brothers.

Old Dragon Government knew that once the brothers were divided and weak, he could gobble them up one at a time until the House of Medicine fell.

This is not a fairy tale — it is true. It has happened in our lifetime in the northern part of our continent. Don't let it happen to us.

Unity and *the excellence of patient care* among the brothers of Medicine is a combination that Dragon Government cannot defeat.

Earnest C. Atkins

Earnest C. Atkins, M.D.
President, MAG

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Barnard, Benjamin C., Muscogee—I&R
P.O. Box 951, Columbus 31902

Bell, Charles B., DeKalb—I&R—IM
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Berman, Irwin R., Glynn—ACT—CRS
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Choi, Usup, Dougherty—N2—ORS
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Lisenby, Michael J., Muscogee—I&R
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Shirah, Mitchell C., Muscogee—I&R
P.O. Box 951, Columbus 31902

Smith, George L., Muscogee—I&R
P.O. Box 951, Columbus 31902

PERSONALS

Third District

The August 15 issue of the *Houston Home Journal* honored **A. G. Hendrick, M.D.,** with an article on his 50 years of service to the people of Houston County.

John H. Robinson III, M.D., of Americus, has been appointed to a second 7-year term on the University System Board of Regents.

Fifth District

Allen B. Filstein, M.D., has opened a dermatology practice in Conyers.

Mark A. Gould, M.D., Medical Director of Brawner Psychiatric Institute, was elected chairman of the Professional and Technical Advisory Committee for the Accreditation Program for Psychiatric Facilities (APPF) of the Joint Commission on Accreditation of Hospitals. Dr. Gould serves with the APPF as a representative of the National Association of Private Psychiatric Hospitals.

William H. Plauth Jr., M.D., an Atlanta pediatrics cardiologist, has recently achieved the rank of Fellowship in the American College of Cardiology.

Seventh District

Ismael Esener, M.D., former emergency room physician at Gordon Hospital, has opened an office in Calhoun to practice obstetrics and gynecology.

The doctor's library at Tri-County Hospital in Fort Oglethorpe has been named in honor of **Edward G. Johnson, M.D.,** a general surgeon of the area for the past 30 years.

Eighth District

Pramod K. Batra, M.D., has recently passed the certifying examination of the American Board of Surgery, Inc.

After 42 years of practice, **Augustus S. Batts, M.D.,** has retired.

Urologist **Arvind M. Patel, M.D.,** has recently set up practice in Douglas.

Ninth District

Rafe Banks Jr., M.D., who began his Gainesville urology practice in 1951, has retired.

SOCIETIES

At their September meeting, the members of the **Cobb County Medical Society** heard MAG President, Earnest C. Atkins, M.D., who spoke on MAG programs, goals, and priorities. This Society was particularly active for 3 days in August when members performed physical examinations on approximately 2,000 Cobb County high school athletes.

On September 13 at the Green Island Country Club the **Muscogee County Medical Society** held a barbecue to welcome the new physicians and their spouses. Special guests were the officers of the MAG.

DEATHS

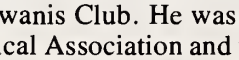
J. L. Tracy

J. L. Tracy, M.D., of Sylvester, died Friday, July 20, after 43 years of medical practice. Born in Worth County, Dr. Tracy attended Mercer University and received his M.D. degree from the Medical College of Georgia. After a 2-year internship in Augusta, he worked at Waverly Hospital, in Louisville, Kentucky, before doing postgraduate work in public health at Vanderbilt University, Nashville.

Dr. Tracy worked as a public health official in Brunswick until his father's death in 1935 when he returned to Sylvester to assume practice as a private physician. At one time, during World War II, he was the only doctor in Worth County.

He served Worth County as a public official in many roles. He was vice-chairman and chairman of the Hospital Authority for Worth County Hospital and Chairman of the Board of Trustees of Worth Community Hospital at the time of his death. He was a frequent hospital Chief-of-Staff, served as county medical examiner for many years, and served as a Worth County Health Department Family Planning Clinic.

A member of Pinson United Memorial Methodist Church, Dr. Tracy served two terms as chairman of the administrative board for the church and was a former president of the Kiwanis Club. He was also a member of the American Medical Association and the Worth County Medical Society.



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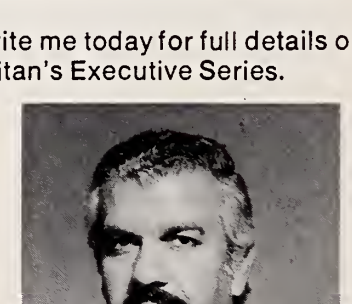
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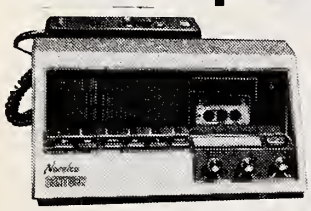

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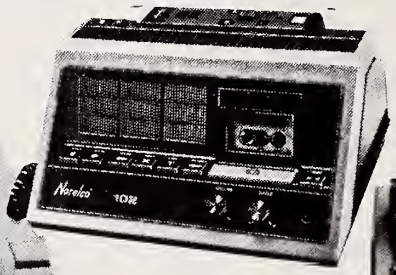

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an, approximately 2% of administered meben- le is excreted in urine as unchanged drug or a ary metabolite. Following administration of 100 mg ebendazole twice daily for three consecutive days, na levels of mebendazole and its primary abolite, the 2-amine, never exceeded 0.03 μ g/ml 0.09 μ g/ml, respectively.

cations VERMOX is indicated for the treatment of *uris trichiura* (whipworm), *Enterobius vermicularis* worm), *Ascaris lumbricoides* (roundworm), *Ancylos- a duodenale* (common hookworm), *Necator ameri- us* (American hookworm) in single or mixed infections. acy varies in function of such factors as pre-existing diarrhea and gastrointestinal transit time, degree of infection and helminth strains.

Contraindications VERMOX is contraindicated in pregnant women (see: Pregnancy Precautions) and in persons who have shown hypersensitivity to the drug.

Precautions *PREGNANCY:* VERMOX has shown embryotoxic and teratogenic activity in pregnant rats at single oral doses as low as 10 mg/kg. Since VERMOX may have a risk of producing fetal damage if administered during pregnancy, it is contraindicated in pregnant women.

PEDIATRIC USE: The drug has not been extensively studied in children under two years; therefore, in the treatment of children under two years the relative benefit/risk should be considered.

Adverse reactions Transient symptoms of abdominal pain and diarrhea have occurred in cases of massive infection and expulsion of worms.

Dosage and administration The same dosage schedule applies to children and adults. The tablet may be chewed, swallowed or crushed and mixed with food.

For the control of pinworm (enterobiasis), a single tablet is administered orally, one time.

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How supplied VERMOX is available as chewable tablets, each containing 100 mg of mebendazole, and is supplied in boxes of twelve tablets.

VERMOX (mebendazole) is an original product of Janssen Pharmaceutica, Belgium, and co-developed by Ortho Pharmaceutical Corporation.

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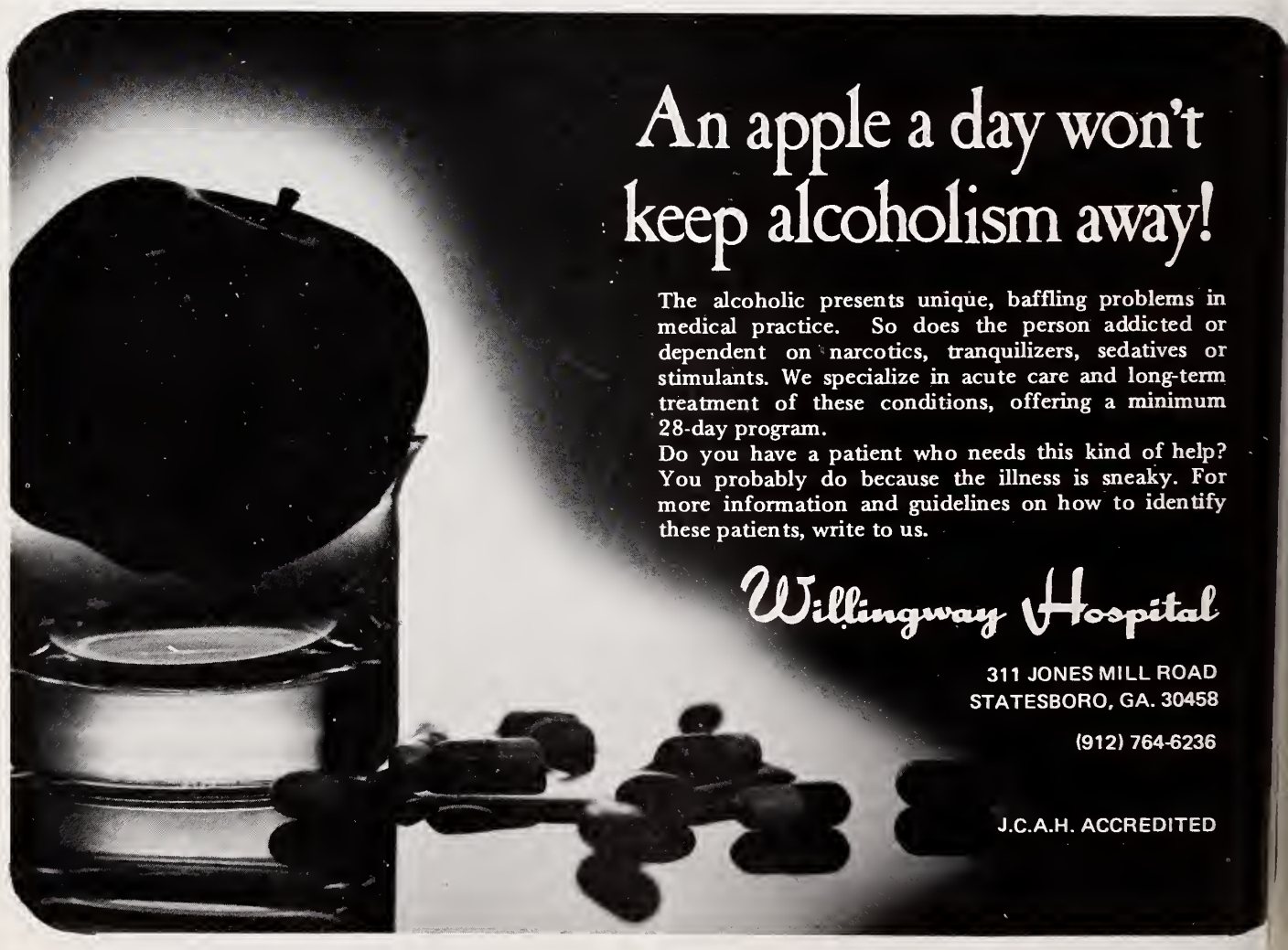
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The Maker

Examining a Few Myths About Prescribing.



Increasing pressure is being put on the practicing physician to prescribe drugs generically. You are told that brand-name products are universally "expensive" and generic versions are relatively "cheap." To make this case, the most extreme (rather than typical) price differentials are cited. Thus, consumers are led to believe that such differentials are commonplace. Even your knowledge and your motives as a physician are questioned.

Understandably, these views have created myths. We think it's time to examine them in the light of all the facts and ramifications.

MYTH: There are no differences in quality and performance between brand-name products and their generic counterparts. The corollary is that there are no differences among products made by high-technology, quality-conscious, research-based companies and those made by commodity-type suppliers.

FACT: The Food and Drug Administration does a good job in monitoring a generally excellent drug supply. Still, it has nowhere near the resources to guarantee the quality and bioavailability of all marketed products at any given time. Just a few months ago, for example, it noted that batches of tetracycline HCl capsules which met official monograph requirements were not bioequivalent to a reference product. As y know, there is substan literature on this subje affecting many drugs, i cluding such antibioti as tetracycline and ery thromycin. The record drug recalls and court actions affirms strongl that there are differen among pharmaceutica companies and their products. Research-intensive companies have far better records than those that do no r search and may practi minimum quality assu ance.

MYTH: Industry favors only "expensive" brand names and denigrates a generics.

FACT: PMA companie make 90 to 95 percen the drug supply, inclu ing, therefore, most o generics. Drug nome clature is not the imp tant point; it's the com tence of the manufac turer and the integrit the product that cour

Matters.

*I: Generic options al-
ılways exist.*

**: About 55 percent
scription drug ex-
ture is for single-
e drugs. This
s, of course, that for
5 percent of such
diture, is a generic
ribing option avail-**

*I: Generic
iptions are filled with
nsive generics, thus
consumers large
of money.*

**: Market data show
ou invariably
ribe—and pharma-
lispense—both
l and generically
d products from
n and trusted
es, in the best inter-
patients. In most
the patient receives
ven brand product.
gs from voluntary
ndated generic
ribing are grossly
erated.**

MYTH: Drugs account for a major portion of the rise in health care costs.

FACT: Drugs represent a very small part of such costs. The amount of the health care dollar spent for prescription drugs was about 12 cents in 1967; today it is about 8 cents. And you as a physician are most conscious of how drug therapy can cut hospitalization, avert surgery, reduce office visits and keep patients on the job.

MYTH: Government intrusions into the marketplace will save tax money.

FACT: Government schemes always cost the taxpayer something, and the costs often exceed the benefits. Certainly, any federal "help," such as lists of wholesale drug prices sent to all physicians and pharmacists, will be no exception. Just think of the expense of keeping them current! Moreover, wholesale prices are poor guides to actual transaction prices and even worse guides to retail prices.

The PMA Position

We believe your freedom to prescribe, either by generic or brand name, should be totally unabridged. Otherwise, your prescribing prerogatives and your relationships with patients will be seriously impaired.

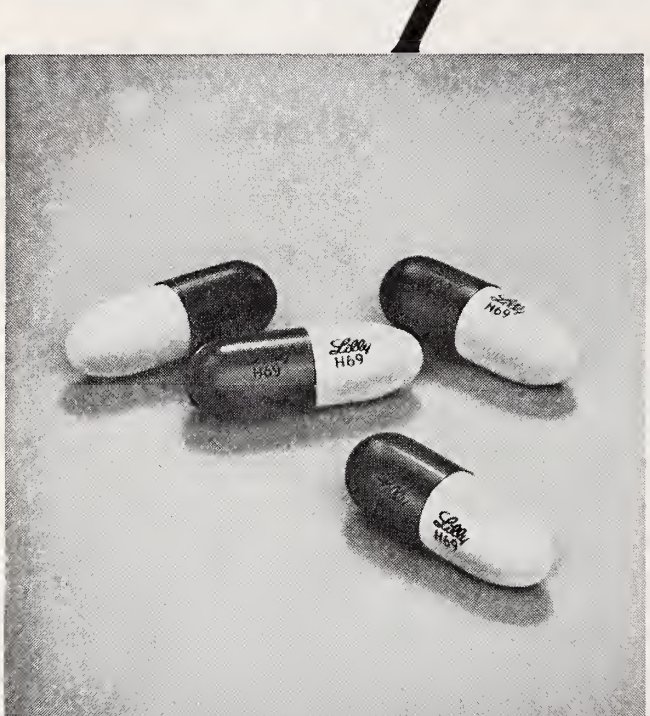
The maker does matter

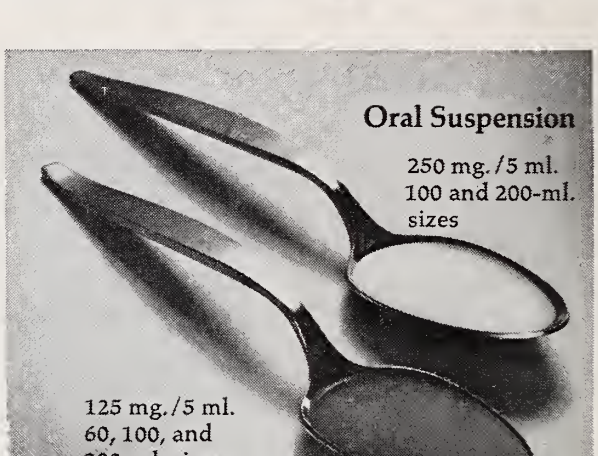
After the myths about price and equivalency have been shattered, one fact stands out more clearly than ever: *The maker does matter.* As always, your best guide to drug therapy for your patients is to select products—both brands and generics—from manufacturers with credentials and performance records you have come to respect.

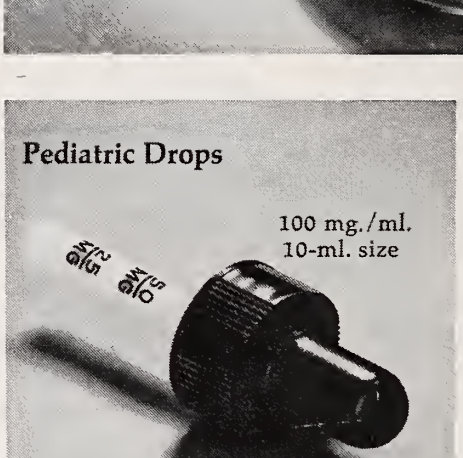
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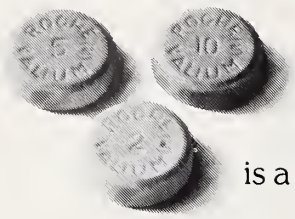
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Valium (diazepam/Roche) is a benzodiazepine with a character all its own. Pharmacologically, it is a potent skeletal muscle relaxant and anticonvulsant (in adjunctive use), as well as an antianxiety agent. Pharmacokinetically, only Valium provides active *diazepam* as well as the active metabolites 3-hydroxydiazepam, desmethyldiazepam and oxazepam.

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Another important aspect of the clinical character of Valium is safety. Though drowsiness, ataxia and fatigue are possible, these and more serious side effects are rarely a problem. Of course, as with all CNS-acting drugs, patients taking Valium should be cautioned against driving, operating dangerous machinery or the simultaneous ingestion of alcohol.

Unquestionably, many psychotherapeutic agents, including other benzodiazepines, have antianxiety effects. But one fact remains: you get a certain kind of patient response with Valium. It's a response you want. A response you know. A response you trust as part of your overall management of anxiety and psychic tension.

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Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology; spasticity caused by upper motor neuron disorders; athetosis; stiff-man syndrome; convulsive disorders (not for sole therapy).

The effectiveness of Valium (diazepam/Roche) in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

Usage in Pregnancy: **Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

Dosage: Individualize for maximum beneficial effect. *Adults:* Tension, anxiety and psychoneurotic states, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. *Geriatric or debilitated patients:* 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) *Children:* 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

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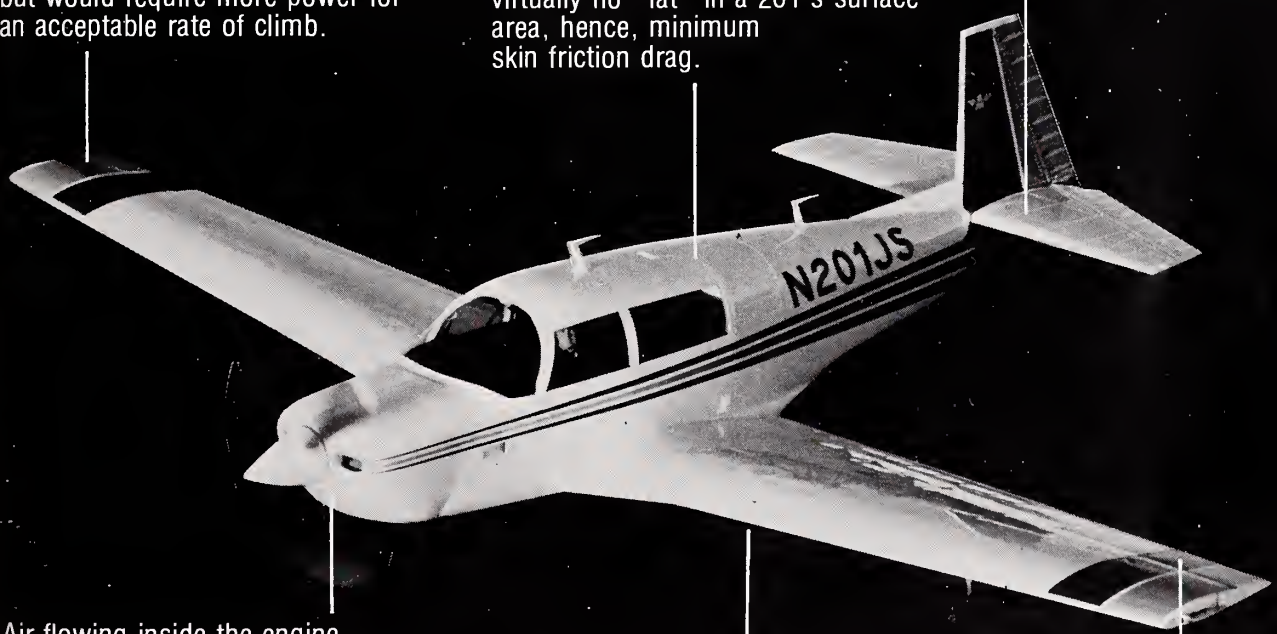
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The callouts on the photograph below highlight the most important ways in which Mooney was able to derive a little over 1 mph top speed for each horsepower. **Epps Air Service** will be glad to show you these design features on the real thing... **a new 201.**

The combined drag of two bodies which are in close proximity is often higher than the sum drag of the individual parts: this "extra drag" is called interference drag. Mooney paid close attention to designing fairings for the flap hinges, horizontal stabilizers, and other areas to reduce this drag.

Mooney's long wingspan provides good rate-of-climb. A shorter span, like the Bonanza's, would add 4-5 mph to the cruise speed, but would require more power for an acceptable rate of climb.

Skin friction drag is a function of square feet of airplane surface exposed to airflow. There's virtually no "fat" in a 201's surface area, hence, minimum skin friction drag.



Air flowing inside the engine cowling creates a large portion of total airplane drag. Mooney's system of internal aerodynamics uses less air more efficiently and provides even cooling to each cylinder.

There are no unnecessary protuberances in the 201. For instance, a low drag electric OAT is used instead of the traditional "meat thermometer" guage sticking through the windshield. The landing gear leg and brake lines are covered with an inboard gear door. The forward half of the wing on both upper and lower surfaces are flush riveted. Inspection panels on the lower surface are flush mounted.

Leakage drag is caused by air flowing to areas where you don't want it to go. For example, high air pressure from the bottom of the wing "leaking" through flap or aileron gaps to the lower pressure top of the wing results in some drag from the leakage flow itself. In addition, the leakage flow exits the leakage path and disturbs the primary flow causing more drag. Gap seals on flaps and control surfaces reduce the 201's leakage drag and provide for better control as well.

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MEDICAL MEETING CALENDAR

DECEMBER

3-7—*Sea Island;* **SCOLIOSIS AND RELATED SPINAL DISORDERS—AN ADVANCED COURSE;** Contact: Robert B. Winter, M.D., American Academy of Orthopedic Surgeons, 444 N. Michigan Ave., Chicago, IL 60610. PH: 312/822-0970.

5-9—*Atlanta;* **FOURTH SOUTHEASTERN CONFERENCE ON ALCOHOL AND DRUG ABUSE;** Category 1 credit; Contact: Conway Hunter, M.D., 2151 Peachford Rd., N.E., Atlanta 30338. PH: 404/455-3200.

6-7—*Atlanta;* **GLAUCOMA UPDATE: ADVANCE IN DIAGNOSIS AND TREATMENT;** Category 1 credit; Contact: Associate Dean for CME, Emory University School of Medicine, 69 Butler St., S.E., Atlanta 30303. PH: 404/588-3534.

7-8—*Lexington, KY;* **BURN SYMPOSIUM;** Category 1 credit; Contact: Frank R. Lemon, M.D., Continuing Education, College of Medicine, University of Kentucky, Lexington, KY 40536. PH: 606/233-5161.

7-9—*Atlanta;* **CARDIAC ISCHEMIA AND ARRHYTHMIAS—CURRENT CONCEPTS FOR DIAGNOSIS AND TREATMENT;** Category 1 credit; Contact: International Medical Education Corp., 64 Inverness Dr. East, Englewood, CO 80112. PH: 800/525-8646.

7-9—*Atlanta;* **SOUTHEAST REGIONAL CONFERENCE, INTERNATIONAL ACADEMY OF PREVENTIVE MEDICINE;** Contact: Joseph A. Nowell, Intl. Academy of Preventive Medicine, 10409 Town and Country Way #200, Houston, TX 77024. PH: 713/468-7851.

8-9—*Augusta;* **SEX AND HANDICAPPED PATIENTS;** Category 1 credit; Contact: Dr. Gerald T. Chambers, Division of Continuing Education, Medical College of Georgia, Augusta 30912. PH: 404/828-3967.

14-15—*Birmingham, AL;* **MKSAP: ALLERGY/IMMUNOLOGY, INFECTIOUS DISEASE, ENDOCRINOLOGY/METABOLISM, ONCOLOGY;** Contact: Jaan Kangilaski, American College of Physicians, 4200 Pine St., Philadelphia, PA 19104. PH: 215/243-1200.

16-18—*Athens;* **TREATMENT OF MENTAL HEALTH PROBLEMS OF THE AGED, UPDATE;** Contact: Don NeSmith, University of Georgia Center for Continuing Education, Athens 30602. PH: 404/542-2242.

24-January 3—*Aspen, CO;* **MEDICAL AND DENTAL LEGAL SEMINARS;** Category 1 credit; Contact: B. J. Cahn, M.D., 3576 Chamblee-Tucker Rd., Atlanta 30341. PH: 404/934-3326.

JANUARY

8—*Atlanta;* **PSYCHOTHERAPY;** Category 1 credit; Contact: Extension Committee, Atlanta Psychoanalytic Society, 3400 Peachtree Rd., N.E., Ste. 913, Atlanta 30326. PH: 404/266-2887.

12-15—*San Antonio, TX;* **AMA WINTER SCIENTIFIC MEETING;** Category 1 credit; Contact: Council on Continuing Physician Education, AMA, 535 N. Dearborn St., Chicago, IL 60610. PH: 312/751-6000.

13-19—*Acapulco, Mexico;* **PEDIATRICS IN REVIEW—1980—THE SCHOOL-AGE CHILD;** Contact: Judson Hawk Jr., M.D., Scottish Rite Hospital, 1001 Johnson Ferry Rd., N.E., Atlanta 30342. PH: 404/256-5252.

21-25—*Snowmass, CO;* **FOURTH ANNUAL CONFERENCE ON PAIN: THE PATIENT WITH CHRONIC LOW BACK PAIN;** Category 1 credit; Contact: Ronald G. Havican, Center for Rehabilitation Medicine, 1441 Clifton Rd., N.E., Atlanta 30322.

21-26—*Augusta;* **THE FIFTEENTH ANNUAL FAMILY PRACTICE SYMPOSIUM;** Category 1 credit; Contact: Dr. Gerald T. Chambers, Division of Continuing Education, Medical College of Georgia, Augusta 30912. PH: 404/828-3967.

26—*Atlanta;* **BORDERLINE PERSONALITY DISORDERS;** Category 1 credit; Contact: Extension Committee, Atlanta Psychoanalytic Society, 3400 Peachtree Rd., N.E., Ste. 913, Atlanta 30326. PH: 404/266-2887.

30-February 1—*Atlanta;* **ANNUAL CONFERENCE, ALLIANCE FOR CONTINUING MEDICAL EDUCATION;** Contact: ACME, 322 Westport Ave., Norwalk, CT 06851. PH: 203/846-3441.

FEBRUARY

4-12—*Atlanta;* **ANNUAL MEETINGS, AMERICAN SOCIETY FOR SURGERY OF THE HAND, ORTHOPEDIC RESEARCH SOCIETY, HIP SOCIETY, AMERICAN ORTHOPEDIC FOOT SOCIETY, AMERICAN ACADEMY OF ORTHOPEDIC SURGEONS;** Contact: American Academy of Orthopedic Surgeons, 444 N. Michigan Ave., Chicago, IL 60611.

7-8—*Augusta;* **PSYCHIATRY;** Category 1 credit; Contact: Dr. Gerald T. Chambers, Division of Continuing Education, Medical College of Georgia, Augusta 30912. PH: 404/828-3967.

8-9—*Gainesville, FL;* **NATIONAL BURN SEMINAR;** Category 1 credit; Contact: Bill Rockwood, Box J-233, J. Hillis Miller Health Center, Office of CME, University of Florida School of Medicine, Gainesville, FL 32610. PH: 904/392-3143

16-20—*Atlanta;* **36TH ANNUAL MEETING, AMERICAN ACADEMY OF ALLERGY;** Contact: American Academy of Allergy, 611 E. Wells St., Milwaukee, WI 53202. PH: 414/272-6071.

21-22—*Atlanta;* **USING VIDEO TECHNOLOGY IN THE CLINICAL SETTING;** Category 1 credit; Contact: School of Medicine, Medical College of Georgia, Augusta 30912.

23—*Atlanta;* **NARCISSISTIC PERSONALITY DISORDERS;** Category 1 credit; Contact: Extension Committee, Atlanta Psychoanalytic Society, 3400 Peachtree Rd., N.E., Ste. 913, Atlanta 30326. PH: 404/266-2887.

28-March 1—*Gainesville, FL;* **7TH ANNUAL SELECTED TOPICS IN UROLOGY;** Category 1 credit; Contact: Bill Rockwood, Box J-233, J. Hillis Miller Health Center, Office of CME, University of Florida School of Medicine, Gainesville, FL 32610. PH: 904/392-3143.

29-March 1—*Birmingham, AL;* **MKSAP: HEMATOLOGY, CARDIOVASCULAR DISEASE, PULMONARY DISEASES, NEPHROLOGY;** Contact: Jaan Kangilaski, American College of Physicians, 4200 Pine St., Philadelphia, PA 19104. PH: 215/243-1200.

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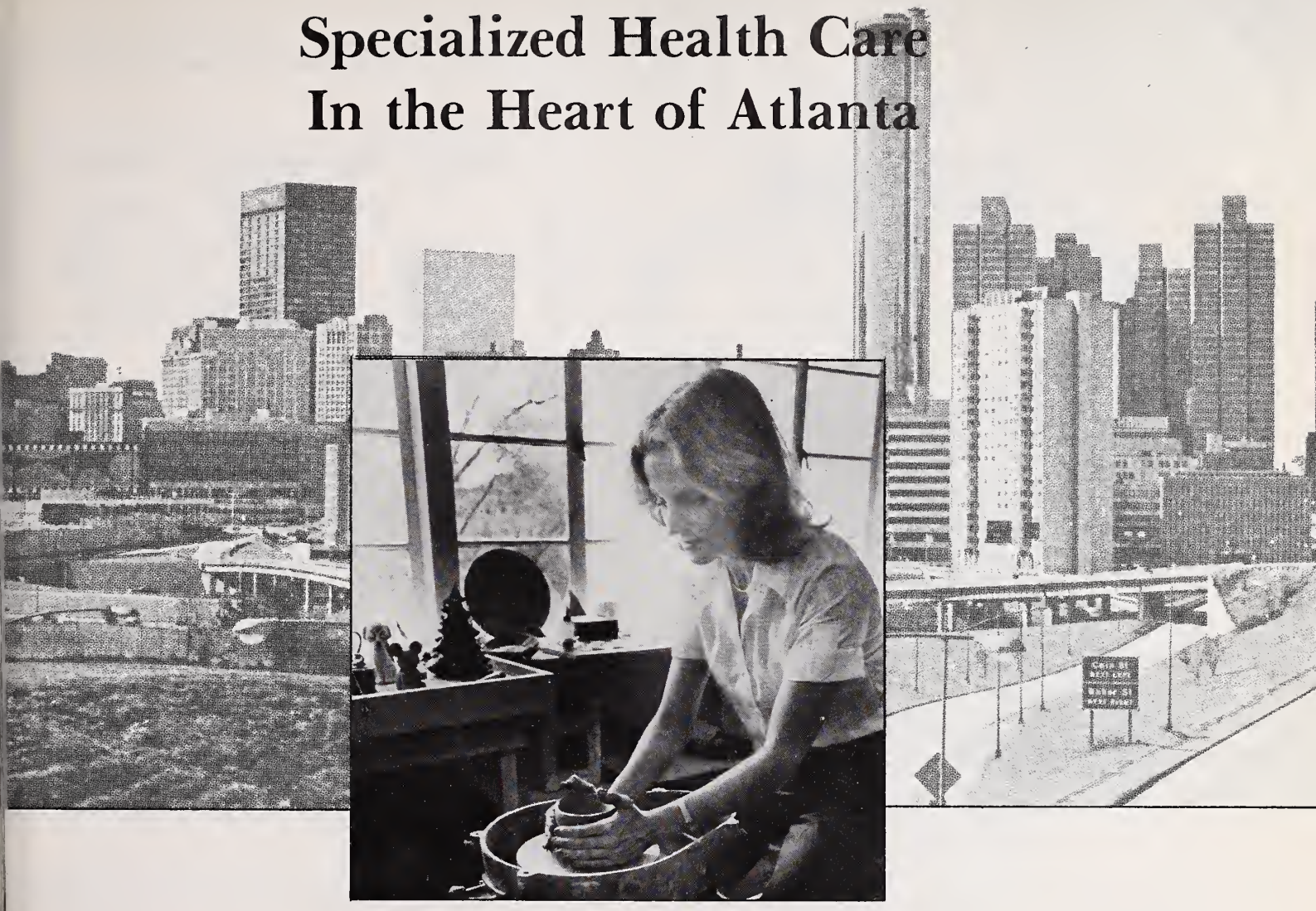
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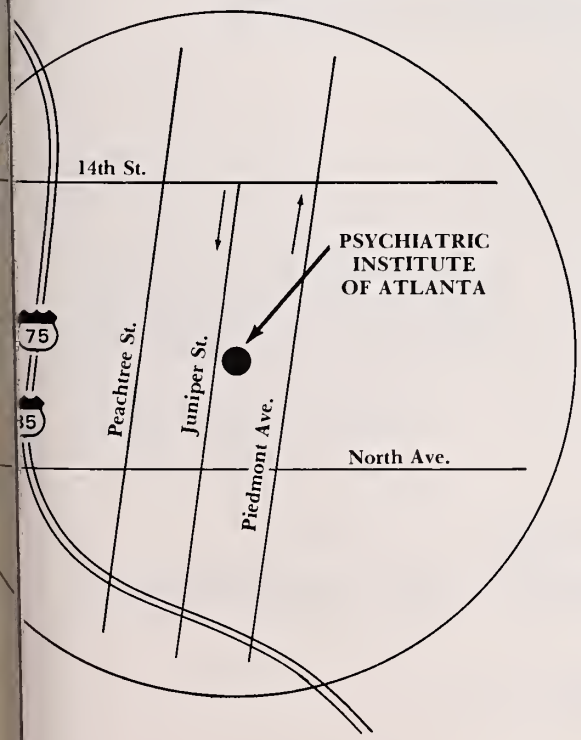
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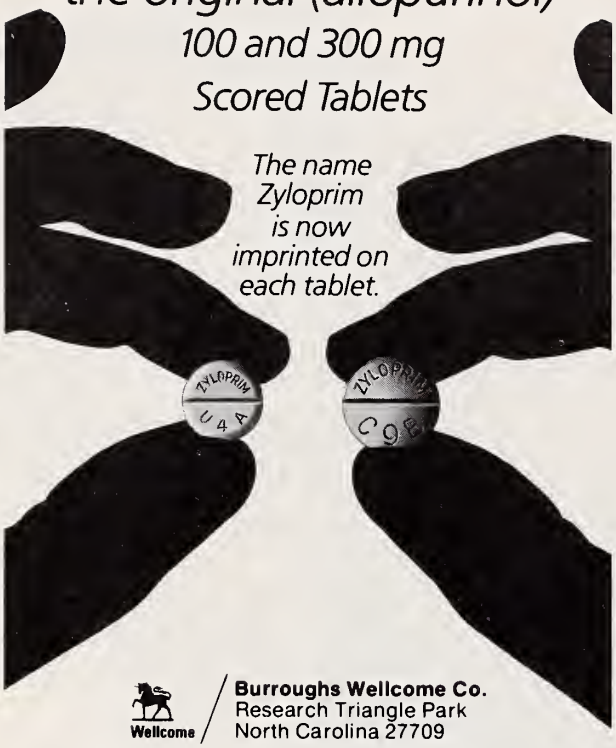
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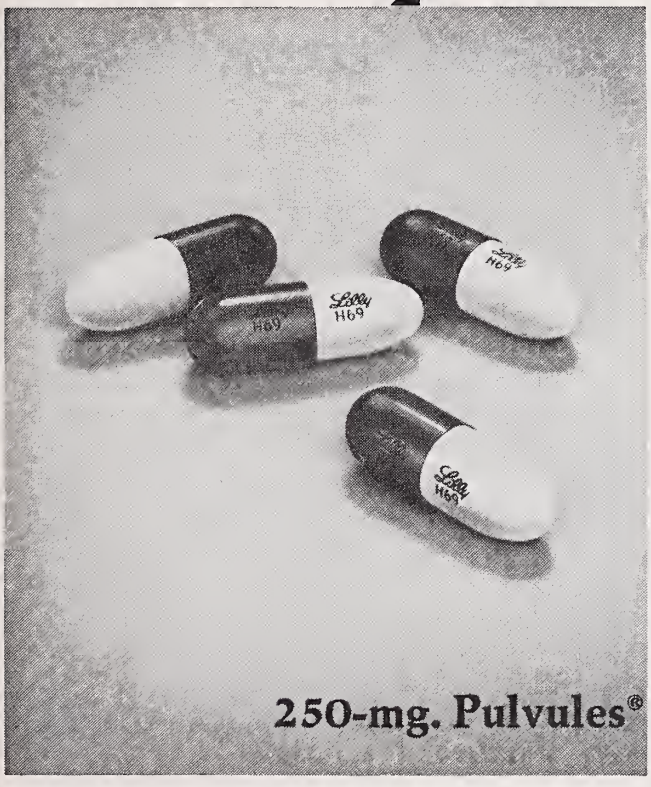
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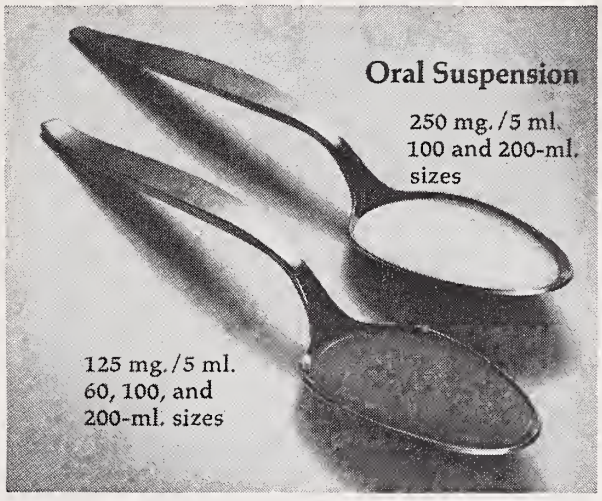
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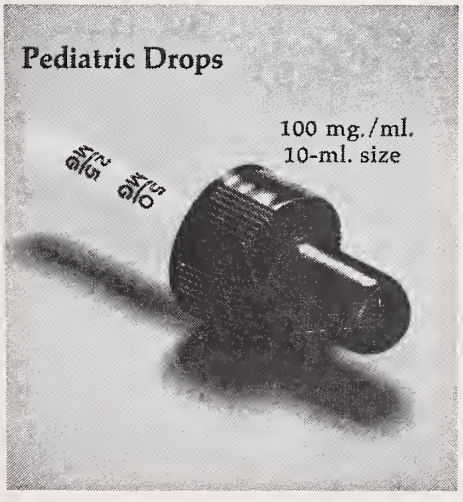
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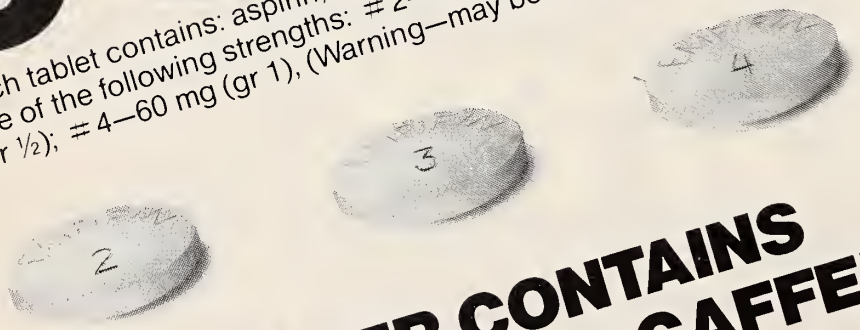
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Pneumatosis Cystoides Intestinalis as Related to Jejuno-ileal Bypass

CHARLES E. WILLS JR., M.D., *Washington**

PNEUMATOSIS CYSTOIDES INTESTINALIS is relatively new in the long list of complications and side effects resulting from jejuno-ileal bypass surgery for morbid obesity. The non-specific symptomatology, benign course and difficulty in making a positive diagnosis without surgery have probably caused many cases to go unrecognized.

This paper presents three case reports of pneumatosis cystoides intestinalis and discusses possible etiologies and problems in diagnosis and treatment, especially when related to the jejuno-ileostomy.

Case Reports

Case #1: This patient was a 50-year-old white woman, 165 cm. (65 in.) tall and weighing 145 kg. (321 lbs.). Her history included gall bladder disease, benign hypertension, recurring pneumonia, migraine headaches, osteoarthritis, and diabetes mellitus.

On Feb. 6, 1969, a cholecystectomy and 35 cm. (14 in.) and 10 cm. (4 in.) end-to-side jejuno-ileostomy was performed. Severe fatty metamorphosis was observed in the liver biopsy. A wound infection occurred postoperatively but subsided spontaneously, and the patient was discharged on the 11th postoperative day. By October 1970, she had lost 45.5 kg. (100 lbs.) but a ventral hernia had developed. This was repaired, and her jejuno-ileostomy was revised to a 35 cm. (14 in.) and 10 cm. (4 in.) end-to-end type. The blind loop was anastomosed to the sigmoid colon for drainage. Severe fatty metamorphosis was still present in the liver. She was discharged on the 11th postoperative day.

In June 1971, inflammatory symmetrical polyarthritis involving the wrist, metacarpophalangeal joints, and metatarsophalangeal joints occurred. She received salicylates and gold salts for these symptoms. The patient's weight at this time was 99 kg. (209 lbs.).

In January 1973, postmenopausal vaginal bleeding occurred. Further examination revealed uterine adenocarcinoma with a single metastatic implant in the left ovary. A total hysterectomy and bilateral salpingo-oophorectomy were performed. Gram-negative sepsis and pneumonia following surgery were successfully treated, and postoperative radiation therapy was subsequently initiated.

Recovery from these problems was slow, and the patient was made miserable by diarrhea, abdominal pain, and nausea. An X-ray in March 1975 suggested pneumatosis cystoides intestinalis. Her weight was 80.5 kg. (177 lbs.), her blood pressure 120/90.

In the ensuing months, she reported six to 10 bowel movements a day. She complained of a very painful place about 6 inches up the rectum where there was a severe burning sensation before, during, and for 15 minutes after every bowel movement. Abdominal bloating and intermittent fever were also present. In October 1977, a diagnostic center elsewhere demonstrated pneumatosis cystoides intestinalis. Proctoscopic examination revealed edema, friability, and bleeding consistent with radiation damage.

In November 1977, her weight was 87 kg. (192 lbs.). She was taken to surgery where pneumatosis cystoides intestinalis was found to be localized in a 61 cm. (24 in.) segment of the lower ileum that started 30 cm. (12 in.) above the ileosigmoidal

* Direct reprint requests to Dr. Wills at 121 Gordon St., Washington, GA 30673.

anastomosis. The sigmoid colon appeared normal. A liver biopsy demonstrated moderate fatty metamorphosis. The diseased segment of the bowel was resected. The intestinal bypass was taken down, and a gastric bypass (Roux-En-Y type) was performed. She was given 1000 cc of whole blood. Postoperatively, the gastroenterostomy stoma was obstructed, so feedings were given through a gastrostomy tube in the bypassed gastric segment. After 12 days, the gastoenterostomy stoma opened, and oral feedings began. The patient was discharged on the 19th postoperative day.

For 2 months, oral feedings were supplemented by gastrostomy tube feedings, because the patient was afraid that she was not getting adequate nutrition orally. For several months, oral feedings were frequently regurgitated into her throat. This eventually ceased.

Her weight finally leveled at 73 kg. (160 lbs.). The severe pain on defecation, abdominal bloating, and migrating arthritis pain have completely disappeared. She has two bowel movements a day. The stool and flatus odor are still objectionable, and she has an area of paresthesia along the right thigh that pains her occasionally. One year after surgery, abdominal gas pains have returned. They are much less severe, however, than before the gastric bypass. She suspects the pneumatosis cystoides intestinalis has recurred, but X-rays have failed to demonstrate any evidence of this. She is more active and looks much better after the gastric bypass.

Case #2: This patient was a 52-year-old white woman who was 155 cm. (61 in.) tall and weighed 119 kg. (262 lbs.). Obesity was first observed at the age of 8. Weight control was unsuccessful in spite of numerous diets, pills, shots, Weight Watchers, Tops, ear staples, and hypnosis. She became unhappy, chronically anxious, and depressed. She complained of chronic fatigue, pressure on the bladder and lower abdomen, and pain in her feet, knees, and back on standing. Her blood pressure had been elevated for 6 years, and she was taking spironolactone (Aldactone) and propranolol (Inderal). In 1973, angina pectoris was diagnosed.

On Feb. 24, 1978, an end-to-side 36 cm. and 10 cm. (14 in. and 4 in.) jejuno-ilestomy and vena cava clipping were performed. She had postoperative tachycardia which was relieved by propranolol. Within a few days, diarrhea developed and became recalcitrant. Some days she reported having 25 bowel movements. Additional symptoms included severe rectal burning, pain, and protrusion, weakness, anorexia, lightheadedness, and visual distortion. Severe symptoms persisted until she was hospitalized on April 18, 1978. Diarrhea and other symptoms were controlled by oral starvation, intravenous electrolyte solutions, amphogel 30 ml. every 4 hours, and deodorized tincture of opium, 1 ml. every 4 hours. She was discharged on this medication and a fat-free diet.

At home, her symptoms quickly returned, and by May 12, 1978, she asked that the bypass be taken down, since her emotional and physical problems were placing an apparently overwhelmingly strain on her. She was subsequently operated on, and a large mass was found in the right abdomen which consisted of the jejuno-ileal anastomosis, terminal ileum, cecum, and ascending colon. There was much swelling, edema, and formation of adhesions. The ileocecal valve was nearly obstructed. The entire mass was resected. The intestinal bypass was taken down, producing normal intestinal continuity. Pathologic examination revealed numerous subserosal cysts and a lesser number of submucosal cysts. Non-caseating heavy granulomatous reaction, with numerous multinucleated giant cells intermingled with histocytes and eosinophils, was seen in the submucosa, subserosa, and adhesions. These involved both the large and the small bowel. Her post-operative course was uneventful physically. The patient suffered an emotional breakdown, however, which was relieved by mild sedation. All of the undesirable side effects of the jejuno-ileal bypass completely disappeared during recovery from surgery. The last time she was contacted, on Oct. 8, 1978, she was symptom-free, except for problems preceding bypass surgery.

Case #3: This patient was a 34-year-old, white woman, 147 cm. (58 in.) in height and weighing 87 kg. (192 lbs.). Obesity began with pregnancy at age twenty. Weight control was attempted for fourteen years using diets and pills, with minimal and transient success. Obesity was threatening her marriage. On Oct. 3, 1969, an end-to-side 35 cm. and 10 cm. (14 in. and 4 in.) jejuno-ileostomy, cholecystectomy for gall stones, tubal ligation, and appendectomy were done. During the postoperative period, a recurring cystitis developed that responded to antibacterial therapy.

By October 1971, she weighed 64 kg. (141 lbs.). Recurring symptoms suggesting partial intestinal obstruction necessitated exploratory surgery. No obstruction was found, but the jejunum measured 53 cm. (21 in.). A total of 18 cm. (7 in.) of the jejunum was resected. One year later, in November 1972, she weighed 75 kg. (165 lbs.), and recalcitrant pelvic symptoms dictated the need for additional surgery. A total hysterectomy was performed, together with ventral hernia repair and revision of the jejuno-ileostomy to an end-to-end type, with 33 cm. of

jejunum and 7.5 cm. of ileum (13 and 3 in., respectively). The blind loop was anastomosed to the transverse colon.

Over the next several years, the patient had a hemorrhoidectomy and was admitted to the hospital several times for bypass enteritis, electrolyte imbalance, and chronic anxiety. Her weight stabilized at 55 kg. (120 lbs.). A flu-like episode developed in another city in October 1978 and was treated with penicillin. This illness was followed by increased diarrhea, cramping abdominal pain, low-grade fever, nausea, and abdominal bloating. She passed a kidney stone. These symptoms persisted, and her weight dropped to 48 kg. (107 lbs.). Extensive diagnostic study failed to reveal a cause for these symptoms. Surgery performed on Jan. 29, 1979, however, revealed pneumatosis cystoides intestinalis on the ascending and transverse colon. Damage was not extensive, and the bypass was taken down. Postoperatively, she continued to have pain until treated for 5 days with oxygen therapy sufficient to produce arterial oxygen pressures to 300 mm Hg.

Etiology

The exact cause of pneumatosis cystoides intestinalis is unknown. Wilson,[1] Passaro,[2] Faloon,[3] and Bray[4] have associated it with bypass enteritis, suggesting that it may be due to an overgrowth of anaerobic bacteria in the blind loop with penetration of the bowel layers and formation of gas pockets. A favorable response to antibiotics lends support to this idea. Martyah and Curtis[5] suggested that it may be due to increased intraluminal pressure from the sigmoid colon after ileosigmoidal anastomosis of the blind loop. Feinberg[6] noted X-ray signs occurring 28 times in 24 of the 148 cases reviewed during the postoperative care in cases where the blind loop was anastomosed to the cecum. In his case report, Manguy[7] postulated volvulus at the ileosigmoidal anastomosis as the cause. Another theory was that the rupture of pulmonary alveoli allows air to enter the mediastinum which then migrates to the retroperitoneal space and to the bowel wall. Mechanical, bacterial, and biochemical theories all exist, but since none completely solve the mystery, the cause may vary according to the underlying pathologic process.[6]

In my experience of 35 years of all types of general abdominal surgery, I have seen only three cases of pneumatosis cystoides intestinalis. All three occurred in patients who had had jejuno-ileal bypass surgery. In one case (#2 reported here), the symptoms occurred so soon after bypass surgery and were relieved so completely when the bypass was taken down that a cause and effect relationship is very strongly suggested.

Diagnosis

Generally speaking, pneumatosis cystoides intestinalis is viewed as a benign disorder.[8] Many cases are asymptomatic. Others present with nausea, vomiting, low-grade fever, diarrhea, abdominal pain, distention, abdominal cramps, and rectal bleeding.

The clinical history is so non-specific that a strong index of suspicion is necessary for diagnosis.[9] The usual accepted diagnostic method is X-ray;[10] however, this is of value only if the picture is positive. In my limited experience, X-ray has contributed little in establishing a diagnosis. Obviously, many cases will be missed if X-ray is relied upon for diagnosis.

Endoscopic diagnosis is also accurate, but again, only if positive.[11] Sigmoidoscopy is limited to examining only the lower large bowel, while colonoscopy is primarily limited to examining the entire large bowel. Both types will therefore miss cases of small bowel disease. Surgery provides the most precise diagnostic approach, but it is a drastic measure for a benign disorder that usually responds to conservative medical therapy.

If the above diagnostic methods, excluding surgery, yield negative results, or surgery is unwarranted, a presumptive diagnosis may be made on the basis of history followed by a favorable response to medical therapy.

Treatment

Asymptomatic cases require no treatment. Patients with mild symptoms may require only observation and symptomatic treatment. More extensive symptomatology should be treated with a short course of antibacterial therapy using metrenidazole (Flagyl), tetracycline, or clindamycin (Cleocin). Another treatment is oxygen therapy for several days in sufficient concentrations to produce arterial oxygen blood gas levels of approximately 250 mm Hg.[11] This can be accomplished with administration of 70% oxygen using a non-rebreathing mask.[12] If extensive damage to the bowel is found at surgery, intestinal resection is indicated.

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The Shape of Things to Come—Medical Care in the 1980's

The character of medical care services and of physicians themselves will undergo dramatic changes in the United States in the 1980's, according to a group of medical experts meeting at an editorial roundtable sponsored by Medical Computer Systems, Inc. (MCSI), of Dallas, for editors of leading medical journals.

There will be less doctors in private individual practices, the group said, and more group practices formed, adding to the more than 8,500 medical groups already registered in the U.S.

If there is enforcement of Section 227 of the 1973 Social Security Amendments, medical instructors could be driven out of medical schools in droves. The legislation could force medical schools to switch from a fee-for-service compensation to a cost-of-service payment system that would reduce the hospital's income from patient health care by as much as 90%. Since most teaching hospitals are state supported, and required by law to continue operating, the lost revenue would simply be made up from the only available source — state or county taxes.

Tomorrow's physician, due in part to compliance with current government regulations, will also have to wear a businessman's hat. This will require that he enter practice with some business education in accounting and management, in addition to his medical training.

Another trend that is becoming more apparent involves government increasing intrusion into the practice of medicine, such as monitoring the number of clinical tests a doctor runs on a patient and the length of hospital stay he prescribes. The obvious effect will be an avalanche of new record keeping requirements and higher operating costs that will have to be passed on to the public. The paradox of this is that the government, on one hand, is putting pressure on physicians to contain costs while at the same time imposing inflationary requirements on them.

The outgrowth of the new emphasis on cost containment and better records keeping is a nationwide move toward computerized record keeping systems provided by data processing service bureaus. With such a system, once a bill has been issued to a patient, payment is tracked to identify unpaid accounts and the length of time they have been delinquent. This will not be welcome news to people who are normally slow or reluctant to pay their medical bills. It will, however, help control costs for the prompt payer.

For further information: David L. Smith, Manager of Marketing Communications, Trans Union System Corporation, Chicago, IL, 312/431-3028.

The data in this report emphasize the potential severity of measles for any child or adult not adequately immunized.

Summertime Measles — Georgia*

In late July the Georgia Department of Human Resources, in collaboration with the Center for Disease Control (CDC), increased surveillance to identify measles cases and to vaccinate susceptible contacts. Surveillance efforts have involved a mailing to all primary care physicians, school principals, day-care centers, primary-care clinics, summer camps, hospitals, military installations, and county health departments. Information about cases was also sought through press releases, radio and television announcements, lectures to selected groups, special telephone calls to pediatricians and day-care centers, and personal visits to numerous county health departments.

From late July through August 31, 1979, 187 reports of suspected cases — many of them delayed reports — were received from these sources. Although serologic testing was performed on a very limited number of suspected cases, 81 or 43.4% met the clinical case definition of measles (fever ≥101 F, rash ≥4 days, and cough, coryza, or conjunctivitis) and were accepted as measles cases (Figure 1). Measles activity was reported in 19 of Georgia's 159 counties, but most cases were concentrated in three counties within the Atlanta metropolitan area. Slightly more than half of the cases occurred among children under 5 years of age, and 28% were in infants under 15 months of age (Table 1). This unusually young age distribution is the result of four separate outbreaks among children attending day-care centers, and two small outbreaks associated with pediatric hospitals, all of which were in the Atlanta metropolitan area.

TABLE 1 — Reported measles cases by age group, Georgia, June 1-August 31, 1979

Age Group	Number of Cases	Percentage
0-5 months	0	0.0
6-14 months	23	28.4
15-23 months	8	9.9
2-4 years	14	17.3
5-9 years	11	13.6
10-14 years	7	8.6
15-19 years	11	13.6
≥20 years	7	8.6
Total	81	100.0

Seven of the 81 cases (8.6%) required hospitalization. Five of these were adolescents or young adults who had a history of receiving killed vaccine. Pneumonia developed in at least four cases, and two of these were diagnosed as atypical measles.

One death from pneumonia and renal failure secondary to measles occurred just before the beginning of summer. This was in a 20-year-old, unvaccinated female who worked as a nurse's aide. She was exposed to a person hospitalized with measles in March.

Editorial Note: Special case-finding and immunization activities have been undertaken this summer in several areas of the country, including Georgia, Los Angeles, and the 10 states comprising HEW Regions VII and VIII.

Because cases were reported from sources which had not previously reported measles cases, and because many cases were found only by more thorough contact tracing, the data from Georgia show that when active surveillance is conducted many cases may be uncovered which would otherwise have gone undetected. In Georgia, persistence of measles virus during the summer appeared to depend in part on

* Reported by JA Alley, MD, C Baker, RN, N Barrett, S Boothe, M Chaney, M Deal, D Duncan, MS, T Fowler, L Griggs, L Howell, H Keown, D Lockridge, B Mayo, RN, S Register, MS, K Schott, T Seegmueller, G Smith, RN, S Stanley, RN, A Sweat, JS Terry, MD, Acting State Epidemiologist, C Turner, Georgia Department of Human Resources; Immunization Division, Bureau of State Services, CDC. Reprinted from the Sept. 14, 1979, issue of the *Morbidity and Mortality Weekly Report*.

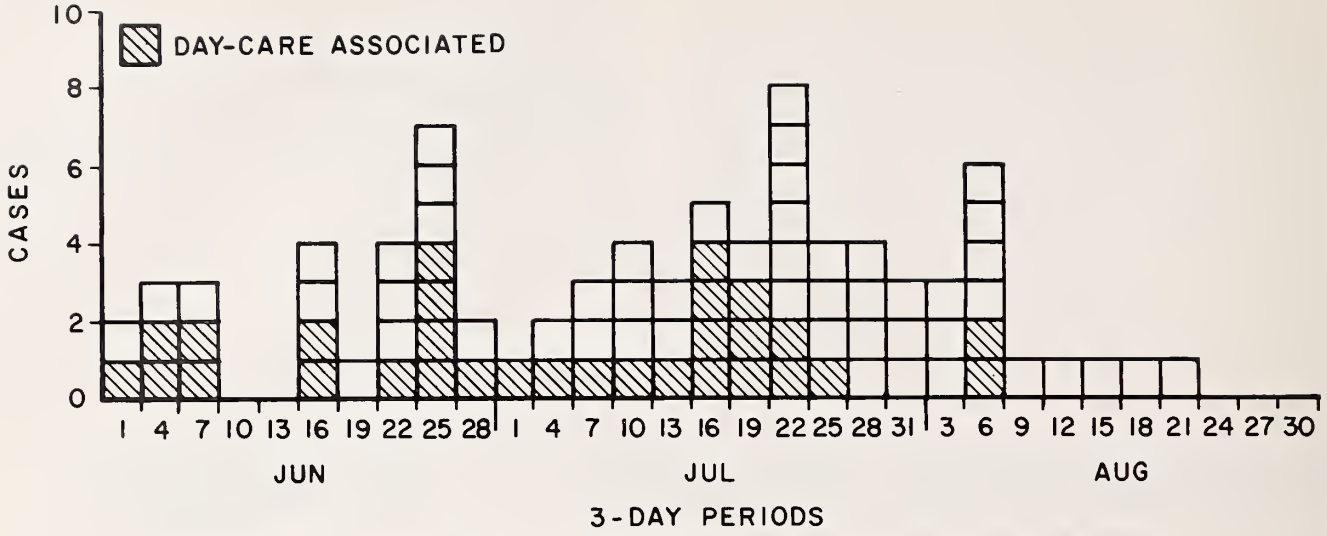


Figure 1. Reported measles cases, by date of onset of rash, Georgia, June 1-August 30, 1979

very young susceptibles, particularly those in day-care centers.

The data in this report also emphasize the potential severity of measles for any child or adult not adequately vaccinated.

As more states increase their active surveillance and case-finding activities, increases in the reported incidence of measles, such as occurred in Georgia, can be expected to occur in at least some of these states. However, as a larger proportion of the total cases are detected, and as control measures are implemented more promptly and more thoroughly, a renewed drop in incidence should occur.

Much attention has been focused on vaccinating school-age children during the National Immunization Initiative. All states now have immunization laws. With the renewed efforts to eliminate measles transmission from the United States, increased attention must be directed to developing and enforcing immunization laws pertaining to preschoolers in day-care centers and in nursery schools. Furthermore, adolescents and young adults beyond high school age should have their immunity status evaluated. All those without a physician-documented history of disease or live vaccine after 12 months of age should be vaccinated.

EDITOR'S NOTE: *Journal* Will Require New Style for Manuscripts

Beginning January 1980, the *Journal* will require a different style for manuscripts submitted for publication. This is being done to comply with the style set forth in the "Uniform Requirements for Manuscripts Submitted to Biomedical Journals" compiled by an International Steering Committee composed of editors of many major medical journals. The purpose of the new recommendations is to achieve a degree of uniformity in manuscripts *(including references)* submitted to medical journals. (To date, they have been as varied as snowflakes.)

Please note the following style change for references listing standard journal articles:

> Soter NA, Wasserman SI, Austen KF. Cold urticaria release into circulation of histamine and eosinophil chemotactic factor of anaphylaxis during cold challenge. N Engl J Med 1976; 294:687-90.

A copy of the complete list of the "Uniform Requirements for Manuscripts Submitted to Biomedical Journals" may be obtained from Edward J. Huth, M.D., Annals of Internal Medicine, 4200 Pine St., Philadelphia, PA 19104.

Clinical Dextran given after Heparin offers good results in preventing recurrent thrombophlebitis and pulmonary embolism.

Dextran or Warfarin: Which Drug to Follow Heparin?

THOMAS R. NOLAN, M.D., A. J. CRUMBLEY, M.D., EDGAR D. GRADY, M.D., and ARNOLD J. ROSEN, M.D., *Atlanta**

Abstract

The records of 32 patients at an East Point, Georgia, hospital with a discharge diagnosis of deep thrombophlebitis treated with Heparin followed by intravenous Dextran from 1973 to 1977 were analyzed for effectiveness of anticoagulation. Heparin was given during hospitalization, and Dextran was started before completion of Heparin therapy and continued on a weekly outpatient basis for 4 to 6 weeks. Of the 32 patients, 30 completed therapy. There were no bleeding complications. One patient received warfarin when Dextran did not control pain and swelling, but on subsequent phlebography proved not to have had deep venous thrombosis. One patient was given warfarin after acute myocardial infarction and pulmonary emboli. One patient had hematologic hypercoagulability and died. No patient receiving Dextran experienced a pulmonary embolism.

Introduction

THE COMBINATION of Heparin and a prothrombin depressing drug has been used as basic therapy for acute deep thrombophlebitis of the lower extremity for many years.[1] In addition, such general measures as bedrest, elevation of the extremity, and elastic compression are widely advocated but are not discussed in this paper. We will refer only to the drugs which interfere with coagulation.

The most common major complication of anticoagulation therapy is hemorrhage, which can be fatal.[2] Pulmonary embolism is the most feared complication of acute deep thrombophlebitis but is fortunately not common.[3] Significant hemorrhage appears to be more of a problem with prothrombinopenic drugs when given in adequate doses than with Heparin given in adequate doses.[4] Our experience is similar. With this in mind, we sought to provide equally effective combination therapy but with fewer complications. Impelled originally by the work of Bryant, Bloom, and Brewer[5] and later by Bergan et al.[6] and Foster et al.,[7] we began to treat patients with acute deep thrombophlebitis using Heparin and Dextran.

Materials and Methods

All patients seen by us with a hospital final diagnosis of acute deep thrombophlebitis of the lower extremity from January 1973 through October 1977 were included in this study. Age and sex distribution are noted in Table 1, and associated diagnosis, if any, in Table 2.

Patients were given Heparin according to laboratory control methods to keep bleeding tests at 2 to 3

TABLE 1 — Age and Sex Distribution of Patients With Acute Deep Thrombophlebitis, January 1973-October 1977, South Fulton Hospital, East Point, Georgia

Age	M	F
≤ 19	1	—
20-29	—	2
30-39	2	3
40-49	1	6
50-59	2	2
60-69	2	4
≥ 70	1	6
Totals	9	23

* Drs. Nolan, Crumbley, Grady, and Rosen are from the Department of Surgery, South Fulton Hospital, East Point, Georgia. This paper was presented at the European-American Symposium on Venous Diseases, Zurich, Switzerland, September, 1978. Send reprint requests to: Thomas R. Nolan, M.D., 101 Cleveland Professional Bldg., Atlanta, GA 30344.

TABLE 2 — Associated Diagnoses of Patients With Acute Deep Thrombophlebitis, January 1973-October 1977, South Fulton Hospital, East Point, Georgia

Postphlebitic syndrome (2)
Varicose veins (2)
Urinary tract infection
Diverticulitis coli
Arterial occlusion
Carcinoma of colon with metastases
Pregnancy
Myocardial infarction with pulmonary embolism
Erythema nodosum
Carcinoma of ovary
Insect bite with superficial phlebitis
Urethral stenosis
Chronic cholecystitis, cholelithiasis, and acute pancreatitis

times control levels. In the beginning, our laboratory used the Lee-White coagulation time, and later in the study converted to the activated partial thromboplastin time (PTT). All of these patients were given Heparin by the intermittent intravenous (IV) method.[1] Heparin was continued usually until fever, tachycardia, and swelling were gone, and then the second stage of medication was started. The duration of Heparin therapy was 6-14 days.

Intravenous 6% Dextran 75 in saline solution was given when the clinical decision was made to begin tapering Heparin soon. The schedule was similar to that used by Bryant et al.[5] We administered 500 ml. IV in the first dose, a second dose of the same amount 1 or 2 days later, and then weekly doses of the same amount for 4 to 6 weeks. After the second dose the patient was seen on an outpatient basis. Our loading dose was thus smaller than Bryant's but the clinical effectiveness appeared to be as great.

Diagnosis was made principally by clinical methods, although phlebography was done in selected instances.

Results

There was neither bleeding nor embolic complications during therapy and no recurrence of acute thrombophlebitis. One patient had recurrent symptoms despite Heparin, Dextran, and warfarin and was later shown by angiography to have normal deep veins. One patient had sustained acute myocardial infarction, phlegmasia cerulea dolens, and pulmonary embolism prior to treatment with Heparin and Dextran and was placed back on warfarin at discharge rather than on Dextran on an outpatient basis. One young man had a diffuse coagulopathy that defied accurate diagnosis by competent hematologists. He had adverse reactions to Dextran, which was discontinued; mesenteric thrombosis developed, and he died. His was the only death in the group.

Under these circumstances, we found that in none of these patients who did not have the "standard" therapy was there any increase in risk of complication or failure of therapy. In fact, there were no failures of treatment in persons with normal coagulation mechanisms and no major complications.

The weekly Dextran dosage schedule seemed adequate, because clinical Dextran with average molecular weight of 75,000 is slowly excreted by the kidney and is active in platelet depression for at least 5 days following a single dose.[5]

Discussion

It has long been considered that the required treatment of acute deep thrombophlebitis includes Heparin and prothrombin depressant therapy. The purpose of these drug regimens is to stop progression of the thrombus, to prevent pulmonary emboli, and to begin resolution of the thrombus.

Heparin remains unchallenged as the drug of choice to stop progression of the thrombus and to initiate resolution of the clot.[8] Prevention of pulmonary embolism is a many-faceted problem served in part by Heparin and in part by other drugs.

The specific drug to follow Heparin and to permit outpatient therapy has largely been a prothrombinopenic drug in recent years. Bryant et al.[5] and Bergan et al.[6] described the use of Dextran for acute thrombophlebitis in one or more of its forms, and Bloom et al.[9] reported the results of using this drug to prevent experimental arterial thrombosis. We propose that warfarin or a similar prothrombin depressant is not necessary and that clinical Dextran given after Heparin offers good results in preventing recurrent thrombophlebitis and pulmonary embolism.

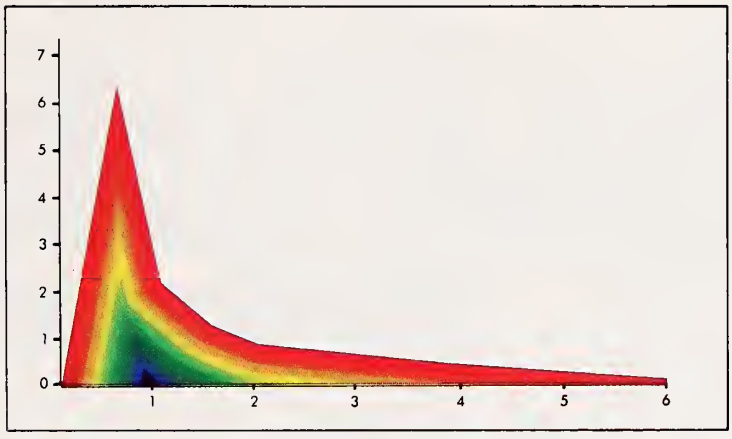
Conclusions

We conclude that intravenous Heparin in adequate doses for a long enough period of time, followed by intravenous 6% Dextran as described, is effective therapy for acute deep thrombophlebitis of the lower extremity. This method of treatment was effective in 30 of 32 patients treated. No patient had pulmonary embolism during or following treatment.

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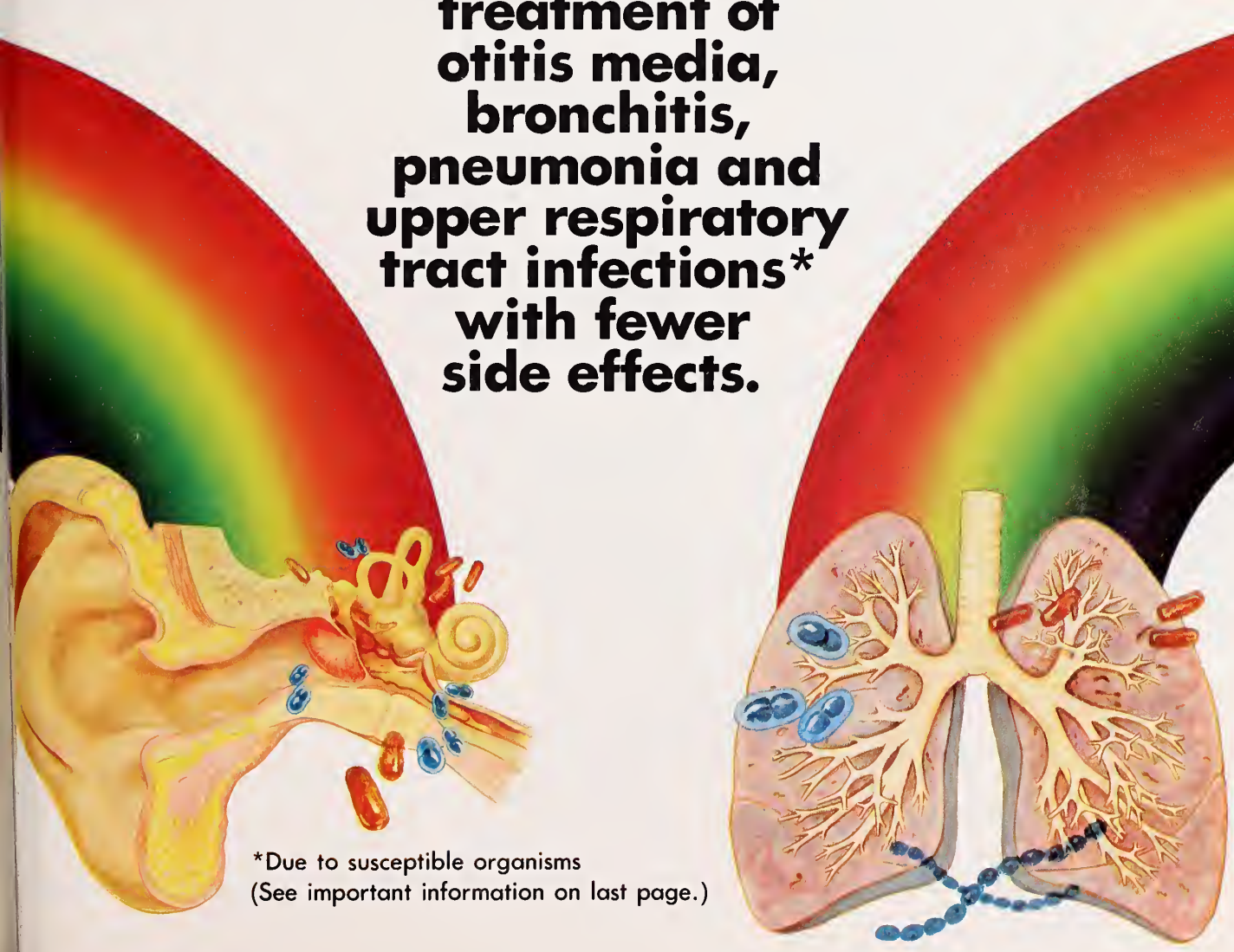
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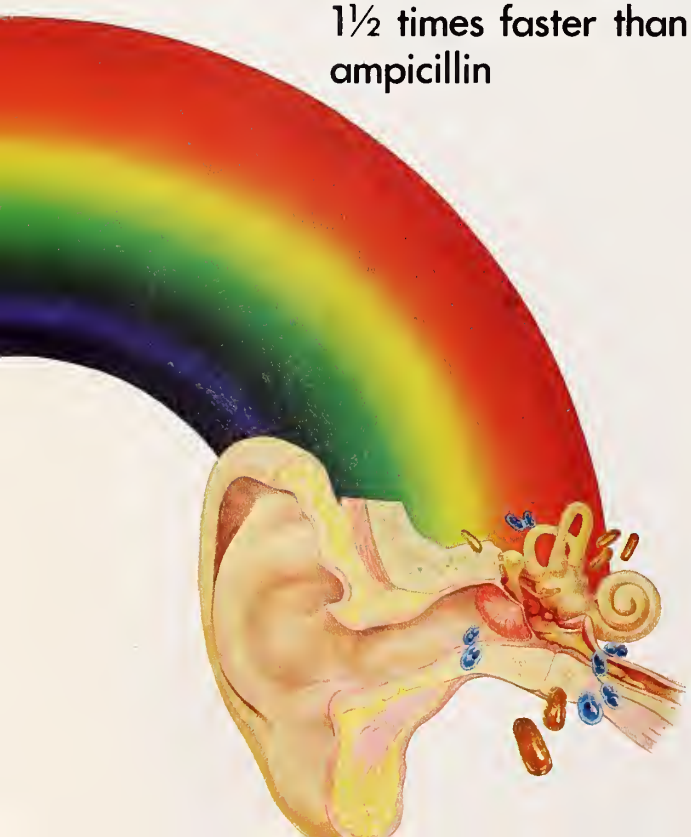
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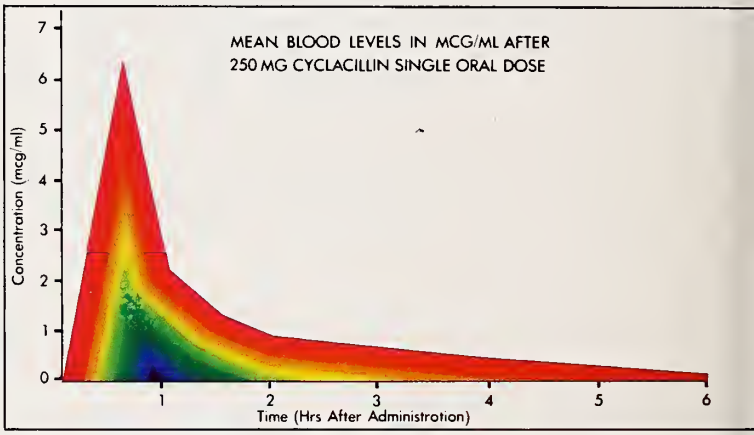
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Acute exacerbation of chronic bronchitis caused by *H. influenzae**
*Though clinical improvement has been shown, bacteriologic cures cannot be expected in all patients with chronic respiratory disease due to *H. influenzae*.

SKIN AND SKIN STRUCTURES (integumentary) infections caused by Group A beta-hemolytic streptococci and staphylococci, non-penicillinase prodocers.

URINARY TRACT INFECTIONS caused by *E. coli* and *P. mirabilis*. (This drug should not be used in any infections caused by *E. coli* and *P. mirabilis* other than urinary tract infections.)

NOTE: Cultures and susceptibility tests should be performed initially and during treatment to monitor the effectiveness of therapy and the susceptibility of bacteria. Therapy may be instituted prior to the results of sensitivity testing.

Contraindications

The use of this drug is contraindicated in individuals with a history of an allergic reaction to penicillins.

Warnings

CYCLACILLIN SHOULD ONLY BE PRESCRIBED FOR THE INDICATIONS LISTED IN THIS INSERT.

CYCLACILLIN HAS LESS *IN VITRO* ACTIVITY THAN OTHER DRUGS OF THE AMPICILLIN CLASS ANTIBIOTICS. HOWEVER, CLINICAL TRIALS HAVE DEMONSTRATED THAT IT IS EFFICACIOUS FOR THE RECOMMENDED INDICATIONS.

SERIOUS AND OCCASIONAL FATAL HYPERSENSITIVITY (ANAPHYLACTOID) REACTIONS HAVE BEEN REPORTED IN PATIENTS RECEIVING PENICILLIN.

ALTHOUGH ANAPHYLAXIS IS MORE FREQUENT FOLLOWING PARENTERAL ADMINISTRATION, IT HAS OCCURRED IN PATIENTS ON ORAL PENICILLINS. THESE REACTIONS ARE MORE APT TO OCCUR IN INDIVIDUALS WITH A HISTORY OF SENSITIVITY TO MULTIPLE ALLERGENS. THERE ARE REPORTS OF PATIENTS WITH A HISTORY OF PENICILLIN HYPERSENSITIVITY REACTIONS WHO EXPERIENCED SEVERE HYPERSENSITIVITY REACTIONS WHEN TREATED WITH A CEPHALOSPORIN. BEFORE THERAPY WITH A PENICILLIN, CAREFUL INQUIRY SHOULD BE MADE ABOUT PREVIOUS HYPERSENSITIVITY REACTIONS TO PENICILLINS, CEPHALOSPORINS, AND OTHER ALLERGENS. IF AN ALLERGIC REACTION OCCURS, THE DRUG SHOULD BE DISCONTINUED AND APPROPRIATE THERAPY SHOULD BE INITIATED. SERIOUS ANAPHYLACTOID REACTIONS REQUIRE IMMEDIATE EMERGENCY TREATMENT WITH EPINEPHRINE. OXYGEN, INTRAVENOUS STEROIDS, AIRWAY MANAGEMENT, INCLUDING INTUBATION, SHOULD ALSO BE ADMINISTERED AS INDICATED.

Precautions

Prolonged use of antibiotics may promote the overgrowth of nonsusceptible organisms. If superinfection occurs during therapy, appropriate measures should be taken.

PREGNANCY. Pregnancy Category B. Reproduction studies have been performed in mice and rats at doses up to ten times the human dose and have revealed no evidence of impaired fertility or harm to the fetus due to cyclacillin. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

NURSING MOTHERS. It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk, caution should be exercised when cyclacillin is administered to a nursing woman.

Adverse Reactions

The oral administration of cyclacillin is generally well tolerated.

As with other penicillins, untoward reactions of the sensitivity phenomena are likely to occur, particularly in individuals who have previously demonstrated hypersensitivity to penicillins or in those with a history of allergy, asthma, hay fever, or urticaria.

The following adverse reactions have been reported with the use of cyclacillin: diarrhea (in approximately 1 out of 20 patients treated), nausea and vomiting (in approximately 1 in 50), and skin rash (in approximately 1 in 60). Isolated instances of headache, dizziness, abdominal pain, vaginitis, and urticaria have been reported. (See WARNINGS)

Other less frequent adverse reactions which may occur and that have been reported during therapy with other penicillins are: anemia, thrombocytopenia, thrombocytopenic purpura, leukopenia, neutropenia and eosinophilia. These reactions are usually reversible on discontinuation of therapy.

As with other semisynthetic penicillins, SGOT elevations have been reported

Dosage and Administration

INFECTION*	ADULTS	CHILDREN
		Dosage should not result in a dose higher than that for adults.
Respiratory Tract		
Tonsillitis & Pharyngitis**	250 mg q.i.d. in equally spaced doses	body weight <20 kg (44 lbs) 125 mg q.i.d. in equally spaced doses body weight >20 kg (44 lbs) 250 mg q.i.d. in equally spaced doses
Bronchitis and Pneumonia		
Mild or Moderate Infections	250 mg q.i.d. in equally spaced doses	50 mg/kg/day q.i.d. in equally spaced doses
Chronic Infections	500 mg q.i.d. in equally spaced doses	100 mg/kg/day q.i.d. in equally spaced doses
Otitis Media	250 mg to 500 mg q.i.d. in equally spaced doses depending on severity	50 to 100 mg/kg/day in equally spaced doses depending on severity
Skin & Skin Structures	250 mg to 500 mg q.i.d. in equally spaced doses depending on severity	50 to 100 mg/kg/day in equally spaced doses depending on severity
Urinary Tract	500 mg q.i.d. in equally spaced doses	100 mg/kg/day in equally spaced doses.

*As with antibiotic therapy generally, treatment should be continued for a minimum of 48 to 72 hours after the patient becomes asymptomatic or until evidence of bacterial eradication has been obtained.

**In infections caused by Group A beta-hemolytic streptococci, a minimum of 10 days of treatment is recommended to guard against the risk of rheumatic fever or glomerulonephritis.

In the treatment of chronic urinary tract infection, frequent bacteriologic and clinical appraisal is necessary during therapy and may be required for several months afterwards.

Persistent infection may require treatment for several weeks.

Cyclacillin is not indicated in children under 2 months of age.

Patients with Renal Failure

Based on a dosage of 500 mg q.i.d., the following adjustment in dosage interval is recommended.

Patients with a creatinine clearance of >50 ml/min need no dosage interval adjustment.

Patients with a creatinine clearance of 30-50 ml/min should receive full doses every 12 hours.

Patients with a creatinine clearance of between 15-30 ml/min should receive full doses every 18 hours.

Patients with a creatinine clearance of between 10-15 ml/min should receive full doses every 24 hours.

In patients with a creatinine clearance of <10 ml/min or serum creatinine values of ≥ 10 mg%, serum cyclacillin levels are recommended to determine both subsequent dosage and frequency

Wyeth Laboratories
Philadelphia, Pa 19101

This study should provide useful information for state officials across the country who have significant rural populations within their states.

Emergency Medical Coordinators: First Responders for Rural Communities

JUSTIN A. MYRICK, Ph.D., BONNIE J. KAY, Ph.D., DARLENE KISHBAUGH, M.S., JULIAN PITTMAN, B.S.E.D., and NELSON SAYFORD, B.S.I.E., *Atlanta**

A PILOT PROJECT is in progress in 36 rural communities in Georgia to determine the usefulness of training and equipping emergency first responders in communities which have no physician or ambulance. There are an estimated 11,000 communities in the United States with a population under 1,000. Most of these have neither a physician nor an ambulance within the community and are thus dependent on neighboring communities for their emergency resources. The first responders are called Emergency Medical Coordinators (EMCs), and this project seeks to determine whether an EMC is a useful alternative to an ambulance service which has proven to be cost-prohibitive in many settings.

Need

There are approximately 54 million persons in the United States who are classified as living in rural areas. While the percentage of the population classified as rural has steadily declined for many years, the actual population of 54 million has remained relatively stable since 1930. Small businesses, however, have greatly declined in these small communities. This has contributed to a loss of the tax base in small rural towns, thus reducing the capability of providing public services. This loss of revenue obviously affects the funding of adequate emergency services.

The National Academy of Sciences-National Research Council has stated that 70% of all traffic fatalities occur in rural areas and in small towns of fewer than 2,500 people. Waller[1] confirms this fact by noting that the injury-fatality rates per 100,000 population for residents of rural California counties are over twice that for urban counties. He studied 2,000 consecutive highway deaths in California and found that 49% of the persons died within the first hour after injury. The importance of rural location upon survival was shown by Waller in a study which indicated that 37% of those who died in the first hour in urban areas died at the site of the injury, compared to 75% in rural areas. These differences could not be explained in terms of greater accident severity, since 53% of the fatal urban crashes were judged to be non-survivable.

Waller also states that 32% of the highway fatalities in rural counties in one study were non-residents, compared to 12% in urban counties. This information indicates the necessity for the urban population to help plan and fund emergency rural services in proximity to urban areas.

While the comments above relate to traffic injuries, many other emergency conditions occur in rural areas which are complicated by the increase in response time. For example, it is generally recognized that a 4 to 6 minute response time is critical for patients with a cardiac arrest. This level of response is possible in most urban and suburban settings but is not possible in most rural areas.

As a whole, the greatest problem in rural areas seems to be that relating to low population density.

* The authors are with the Health Systems Research Center, Georgia Institute of Technology, Atlanta, GA. This project is sponsored by Grant HS02507 from the National Center for Health Services Research, OASH. Direct reprint requests to Dr. Myrick, School of Health Systems, Georgia Institute of Technology, Atlanta, GA 30332.

This factor is responsible for an increased response time, low utilization of facilities and personnel, insufficient funding to provide quality services, and insufficient planning.

The Emergency Medical Coordinator

The project staff selected a group of rural Georgia communities who had neither a physician nor an ambulance service within the community and thus were dependent upon neighboring community resources. These communities all had a population of less than 2,000.

The first step in the selection process was to identify a sponsoring organization within each community who would select the volunteers. The sponsor in many communities consisted of the mayor and city council; in others it consisted of a community group such as the Lions Club, the PTA, or the volunteer fire department. The project was designed to allow the selection of two volunteers per community. A primary objective of this small number was to keep training costs low.

An audio-visual presentation was assembled, and the EMC concept was presented to each community's sponsoring group which then selected the volunteers according to specific criteria developed by the project staff. These criteria included: (1) A person who lived and worked within the community, thus assuring general availability of the person at all times; (2) a long-time resident of the community, providing a person which the community would know and trust; (3) one in good physical condition; (4) someone who had access to a car at all times; (5) a person who was always near a telephone and preferably a private line; (6) one with an outgoing personality, who was able to sell the concept to the community; (7) a person with a genuine interest in becoming an EMC; (8) a quick learner, one who could master the skills required in first aid; and (9) a community leader in either a formal or an informal capacity.

Training for the EMC

In 36 communities, a total of 69 EMCs were selected and brought to Atlanta to receive a 40-hour program in emergency care. This course was sponsored by the Atlanta Area Technical School which certified each EMC in Crash Injury Management, a program developed by the U. S. Department of Transportation. The primary instructor for the course was Judge Arthur M. Kaplan of Atlanta who provided the lectures. Several instructors provided the practical experience in small group settings. The course was given from Friday evening through Sunday for two weekends in July 1978. The emphasis of the course was to teach basic resuscitation and stabilization skills to enable the volunteer to keep a patient alive until professional help arrived. Weekend refresher training programs of 10 hours were held at 6-month intervals to maintain skill levels and volunteer interest in the project. The refresher training is a very important part of the project, since the frequency of calls is low in these rural towns and loss of skills due to inactivity can be great.

The Design of the System

The EMC program was designed to be different from a traditional first-responder program in several ways. First, instead of a person volunteering to be trained for the program, the volunteers were selected by the community, and therefore were volunteers only in the sense of not being compensated. Second, the EMCs were well equipped with a modern first-aid kit consisting of all of the stabilization equipment and materials which they were trained to use. As an added community involvement mechanism, each community was asked to purchase one of the two kits, and the project furnished the second kit. These kits were purchased for approximately $250 each. Third, a system of organized response was developed. Telephone stickers were printed which informed callers during a medical emergency to first call the ambulance or ambulances which served their community and then call the EMC nearest to their location. The specific ambulance numbers were listed with the specific EMC numbers. Thus, the phone stickers for each community contained community-specific information. It was emphasized to all EMCs and to all communities that this program was not to replace, circumvent, or otherwise hinder the existing ambulance which serves the community but rather to provide stabilization support for a seriously-ill patient until an ambulance arrived.

In addition to the phone stickers, other media were used in publicizing the EMC program and the EMC phone numbers. This included periodic publicity in the local newspapers and radio stations, posters which were displayed in various parts of the community, and presentations at local meetings such as PTA, city council, and others.

Evaluation

A critical component of this project is an evaluation of its impact. The study has been designed to assess the most efficient approach to identifying effective volunteers, to measure the appropriateness of volunteer training and response to emergency incidents, and to measure changes in awareness by community residents of how to use the emergency care system.

It is anticipated that community involvement will aid in the diffusion of the EMC concept and acceptance of the volunteers. A first-responder system

works only if it is used. Simply training people in emergency first-aid procedures does not assure that others will call such persons at the time of the accident. It is therefore important to involve the community in the selection of EMCs.

An incident report form was developed to collect data necessary to evaluate the performance of an EMC as a first responder. The form is self-administered and is completed by the EMC on the occasion of an emergency call. Items recorded include response time, type and severity of the illness, and actions taken by the EMC. Completed forms are mailed to the project staff for tabulation and analysis. A telephone survey was designed to measure the project's impact on community awareness regarding how to access the EMS system when necessary. A randomly selected sample of households was surveyed before any community contact was made by project staff and again 5 months after the training program was completed. A third survey will be conducted 12 months after training. Comparisons of community awareness will be made before and after project implementation.

Progress to Date

The EMCs have been working in their communities since the completion of their training at the end of July 1978. The emergency calls have ranged from maintaining an airway and performing cardiopulmonary resuscitation to such non-emergency calls as taking blood pressures. Some non-emergency calls were expected early in the project as the community learned about the program and what the EMC was trained to do. As community confidence in the EMC's skills develops, it is expected that an increasing percentage of calls will be true emergencies. A final analysis of the characteristics of calls made to EMCs will be completed at the termination of the project.

Since initial project training, several EMCs have taken Emergency Medical Technician courses sponsored by local emergency care personnel. Others have accompanied ambulance personnel as observers on emergency trips as a means of continuing education and to acquaint the EMCs with ambulance company personnel who will be responding in the EMC towns.

An example of this cooperation can be seen in Pike County which has no physician or ambulance within the county borders. The sheriff and nine EMCs in five communities within the county have developed a plan which assigned each volunteer a given territory within the county. When the sheriff receives an emergency call, neighboring ambulance companies are first notified, then the closest EMC is contacted.

Significance of the Study

A well-trained, well-motivated EMC should be effective in providing first aid as the initial resource in a coordinated response system if properly supported by the community. The numerous small communities in the United States with no community emergency resources could be aided greatly with an organized first-response program. This study will provide valuable information for state officials across the country who have significant rural populations within their states. Information anticipated by this study includes the determination of the effectiveness of the EMC, the usefulness and practicality of the selection criteria, the proper procedures in selecting EMCs and setting up the program, the types of training experiences which are most beneficial, community awareness and acceptance of the program, and the costs involved in program implementation.

Reference

1. Waller JA: Emergency health services in areas of low population density. JAMA 1969; 207:2255-2258.

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Peachford is a full-service 204-bed psychiatric hospital, providing short, intermediate and long-term treatment programs for adults, children and adolescents. Hospital care is available to all patients regardless of the severity of their illness or of complicating addictions or medical problems.

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As with surgical synovectomy, patients treated at earlier (or less active) stages of their disease fare best.

Radioactive Yttrium-90 Intra-articularly for the Treatment of Rheumatoid Arthritis — 1-Year Follow Up

JOHN M. McCOY, M.D., F.A.C.P., *Atlanta**

FIVE PATIENTS with active (classical or definite) rheumatoid synovitis of the knee were treated by intra-articular injection of 5 mCi yttrium-90 hydroxide (^{90}Y) and evaluated periodically for 1 year. Distribution of ^{90}Y in animals and these patients was reported earlier.[1]

Parameters used to evaluate the degree of disease activity were knee circumference, knee extension, heel to ischial spine distance, and 50-foot walk. Evaluation of the general disease activity was evaluated by counts of active large and small joints (soft tissue swelling, warmth, tenderness, effusion), and the erythrocyte sedimentation rate (Westergren). The shoulders, elbows, wrists, hips, knees, and ankles were considered large joints, and the other peripheral joints were classified as small.

No patient had any local or systemic adverse reaction to the intra-articular injection of ^{90}Y.

After 3 months of treatment, patients RTC and CLB showed improvement in knee circumference and heel to ischial spine distance (Table 1). Two patients (TLR and TRB) showed no significant change. It should be noted that these two patients had extensive active disease (many active joints and sedimentation rates of the order of 100 mm/hour). The remaining patient (LMV) had progressive disease, including the injected joint. At the end of 1 year, one patient (CLB) maintained improvement. In fact, she showed no evidence of synovitis. Note that there was little systemic disease.

Radiographs of the knees before treatment and after 1 year revealed no change except a slight increase in effusions. Pre-treatment with intra-articular corticosteroid to decrease inflammation and spread of radioactive yttrium from the joint accounts for reduced effusions at the time of treatment.

Summary

Yttrium-90 has been shown to effectively control synovitis in the knee by numerous investigators in Europe.[1] Of the five patients reported here, one maintained improvement at 12 months, one was improved at 3 months but lost the benefit by 6 months, and three either showed no benefit or a continued progression of disease. It is probable that the degree of disease activity is of paramount importance and, as with surgical synovectomy, patients treated at earlier stages (or less active stages) of their disease fare best. Two patients (TRB & RTC) were men weighing 205 pounds and 180 pounds, respectively, with large knees in whom a larger dose might have been more effective. The treatment and study of additional patients using a simplified protocol is planned.

* Dr. McCoy practices internal medicine and rheumatology. His address is 993 Johnson Ferry Road, NE, Atlanta, GA 30342.

TABLE 1 — Evaluation of Five Patients Following ^{90}Y in Knee, Georgia, 1979

Patient		RTC	CLB	LMV	TLR	TRB
1. Circumference Knee (cm)	Before	38.74	39.00	31.50	30.50	40.00
	3 mos.	30.81	37.50	35.00	30.79	41.90
	6 mos.	38.74	35.00	35.00	31.10	43.20
	12 mos.	39.68	35.00	35.00	31.10	44.10
2. Knee Extension	Before	180°	170°	170°	180°	165°
	3 mos.	180°	180°	165°	180°	175°
	6 mos.	180°	180°	175°	180°	165°
	12 mos.	175°	180°	155°	180°	165°
3. Heel to Ischial Spine (cm)	Before	16.50	11.40	15.90	12.70	20.30
	3 mos.	12.70	5.08	50.80	17.70	20.30
	6 mos.	20.32	5.10	38.10	20.30	30.50
	12 mos.	22.86	5.08	43.18	20.30	25.40
4. 50-Ft. Walk	Before	11 sec	11 sec	13 sec	35 sec	14 sec
	3 mos.	10 sec	11 sec	21 sec	30 sec	13 sec
	6 mos.	8 sec	11 sec	12 sec	32 sec	14 sec
	12 mos.	9 sec	11 sec	33 sec	32 sec	15 sec
5. Active Large Joints	Before	3	1	3	4	10
	3 mos.	4	0	6	9	8
	6 mos.	9	0	6	12	10
	12 mos.	6	1	15	8	12
6. Active Small Joints	Before	8	0	0	0	20
	3 mos.	15	0	0	0	19
	6 mos.	17	0	0	0	19
	12 mos.	12	0	9	1	20
7. Sedimentation Rate	Before	7	13	14	112	94
	3 mos.	18	20	40	92	102
	6 mos.	26	20	30	110	88
	12 mos.	18	18	58	35	88

Acknowledgement

This study was supported in part by grants from (1) Northside Medical Research and Educational Institute, Incorporated, Mr. Roland P. Smith, Registered Agent, 3151 Maple Drive, NE, Atlanta, Georgia 30305, (2) Arthritis Foundation, Georgia Chapter, 2799 Delk Road, SE, Marietta, Georgia 30067. Sincere appreciation is expressed for the valuable, technical contribution of Mrs. Sherry Chastain, R.T. (ARRT), and the assistance and advice of Neal Chandler, M.D., Gwynne T. Brunt, M.D., and Alvin Moses, M.S.

Reference

1. McCoy JM. Radioactive yttrium-90 intra-articularly for the treatment of rheumatoid arthritis. JMAG 1978;67(5):361.

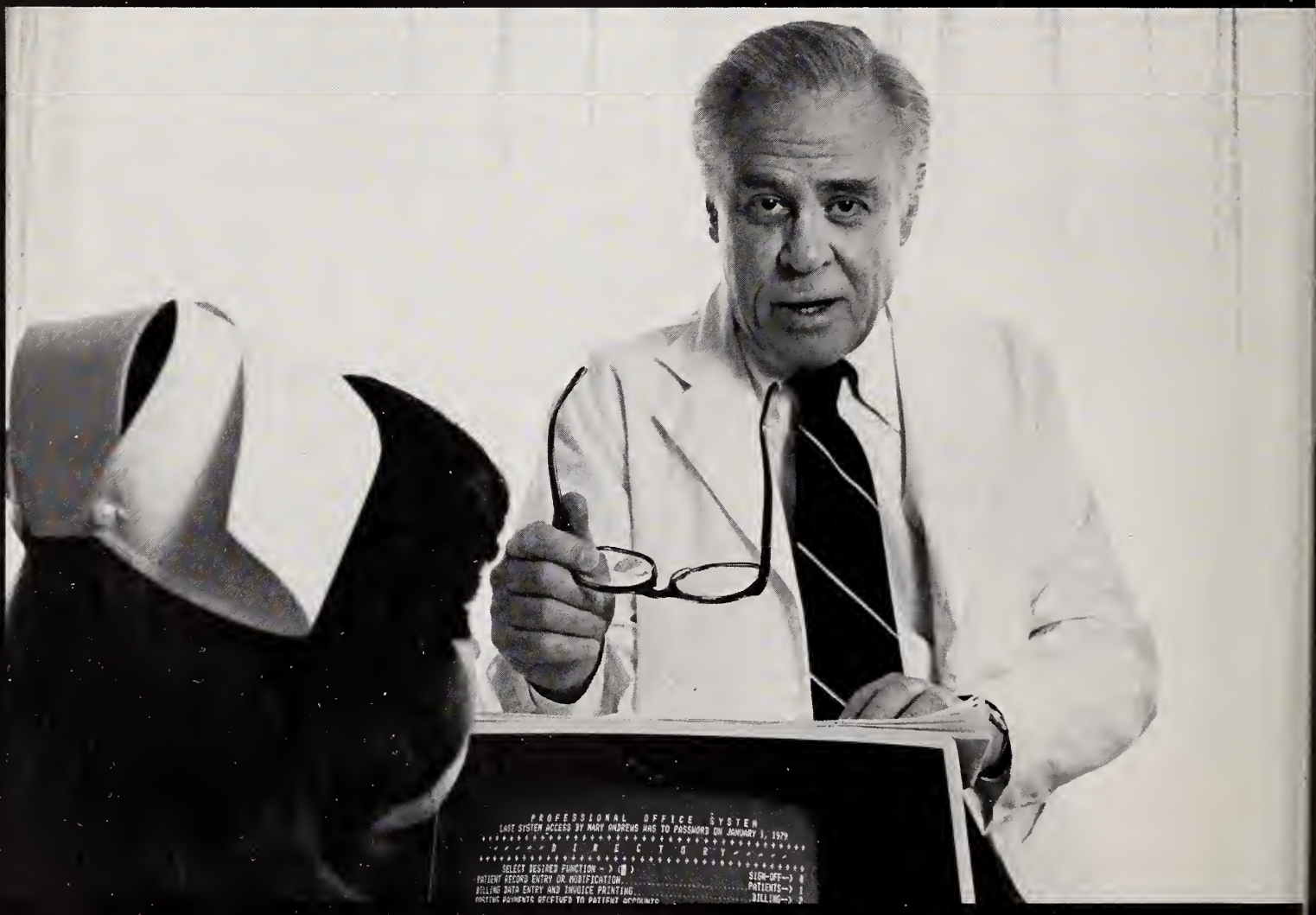
New Social Security Disability Handbooks Available

The Social Security Administration has recently completed a revision of the regulations pertaining to disability evaluation. This revision reflects current advances in medical diagnosis and important changes in evaluating certain impairments.

To assist physicians in understanding the revised criteria utilized in evaluating disability claims, a new handbook has now been released, *Disability Evaluation Under Social Security — A Handbook for Physicians.* This information is of vital importance to the physician who wants to better serve his disabled patients.

The Disability Adjudication Section, which processes all Social Security and Supplemental Security Income (SSI) Disability claims for Georgia, will be distributing the new handbooks through the local county medical societies at their regular meetings. If you have not received your free copy, please call or write: Mr. Roger L. Gardner, Professional Relations Coordinator, Disability Adjudication Section, 1 West Court Square, Suite 300, Decatur, Georgia 30030. Ph: (404) 656-6218.

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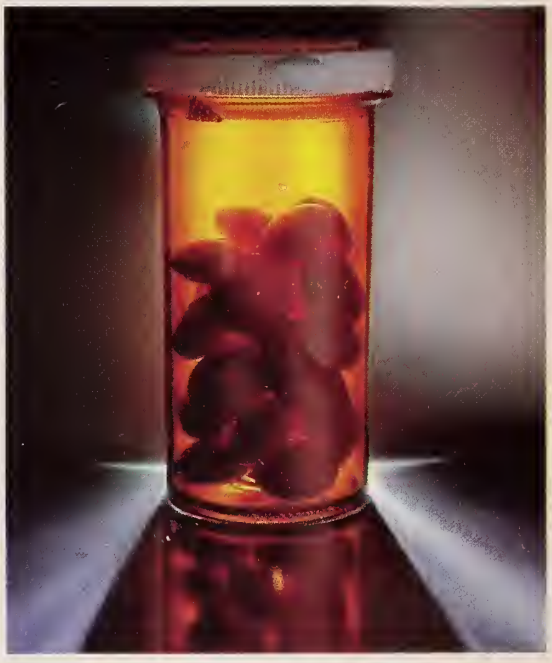
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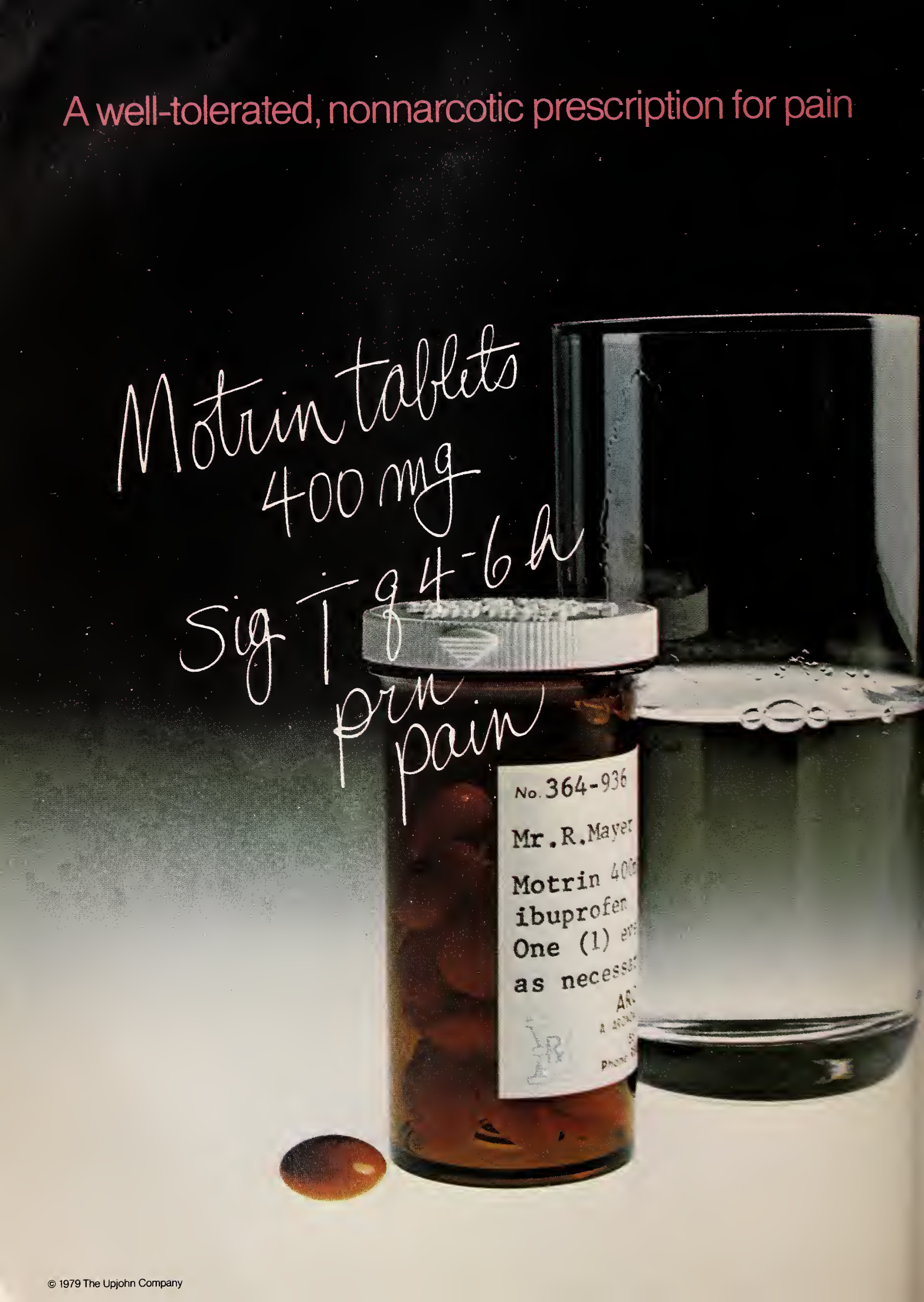
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Motrin now proved an effective analgesic for mild to moderate pain

Motrin 400 mg provided greater relief of pain than did propoxyphene 65 mg in controlled clinical pain studies.

Time after drug administration (hour)		.5	1	2	3	4
Mean relief-of-pain scores* (No. patients reporting)	Motrin 400 mg ibuprofen	.89 (108)	1.25 (108)	1.36 (108)	1.28 (107)	1.19 (106)
	Darvon 65 mg propoxyphene	.66 (100)	.99 (99)	1.13 (96)	.99 (96)	.80 (96)
Statistical significance		$p<0.02$	$p<0.01$	$p<0.05$	$p<0.02$	$p<0.002$

*0 = No relief 1 = Partial relief 2 = Complete relief

Data on file at The Upjohn Company

Motrin demonstrated statistically significant greater relief of pain than did Darvon at all time intervals.

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- Not a narcotic • Not addictive • Not habit forming
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Motrin® (ibuprofen) now proved an effective analgesic for mild to moderate pain

Motrin® Tablets (ibuprofen, Upjohn)

Indications and Usage: Treatment of signs and symptoms of rheumatoid arthritis and osteoarthritis during acute flares and in long-term management. Safety and efficacy have not been established in Functional Class IV rheumatoid arthritis.

Relief of mild to moderate pain.

Contraindications: Individuals hypersensitive to it, or with the syndrome of nasal polyps, angioedema and bronchospastic reactivity to aspirin or other nonsteroidal anti-inflammatory agents (see WARNINGS).

Warnings: Anaphylactoid reactions have occurred in patients with aspirin hypersensitivity (see CONTRAINDICATIONS).

Peptic ulceration and gastrointestinal bleeding, sometimes severe, have been reported. Ulceration, perforation, and bleeding may end fatally. An association has not been established. Motrin should be given under close supervision to patients with a history of upper gastrointestinal tract disease, only after consulting ADVERSE REACTIONS.

In patients with active peptic ulcer and active rheumatoid arthritis, nonulcerogenic drugs, such as gold, should be tried. If Motrin must be given, the patient should be under close supervision for signs of ulcer perforation or gastrointestinal bleeding.

Precautions: Blurred and/or diminished vision, scotomata, and/or changes in color vision have been reported. If these develop, discontinue Motrin and the patient should have an ophthalmologic examination, including central visual fields.

Fluid retention and edema have been associated with Motrin; use with caution in patients with a history of cardiac decompensation

Motrin can inhibit platelet aggregation and prolong bleeding time. Use with caution in persons with intrinsic coagulation defects and those on anticoagulant therapy.

Patients should report signs or symptoms of gastrointestinal ulceration or bleeding, blurred vision or other eye symptoms, skin rash, weight gain, or edema.

To avoid exacerbation of disease or adrenal insufficiency, patients on prolonged corticosteroid therapy should have therapy tapered slowly when Motrin is added.

Drug interactions. *Aspirin:* used concomitantly may decrease Motrin blood levels. *Coumarin:* Bleeding has been reported in patients taking Motrin and coumarin.

Pregnancy and nursing mothers: Motrin should not be taken during pregnancy or by nursing mothers.

Adverse Reactions

Incidence greater than 1%

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*Incidence 3% to 9%.

Incidence less than 1 in 100

Gastrointestinal: Upper GI ulcer with bleeding and/or perforation, hemorrhage, melena. **Central Nervous System:** Depression, insomnia. **Dermatologic:** Vesiculobullous eruptions, urticaria, erythema multiforme. **Cardiovascular:** Congestive heart failure in patients with marginal cardiac function, elevated blood pressure. **Special Senses:** Amblyopia (see PRECAUTIONS). **Hematologic:** Leukopenia, decreased hemoglobin and hematocrit.

Causal relationship unknown

Gastrointestinal: Hepatitis, jaundice, abnormal liver function. **Central Nervous System:** Paresthesias, hallucinations, dream abnormalities. **Dermatologic:** Alopecia, Stevens-Johnson syndrome. **Special Senses:** Conjunctivitis, diplopia, optic neuritis. **Hematologic:** Hemolytic anemia, thrombocytopenia, granulocytopenia, bleeding episodes. **Allergic:** Fever, serum sickness, lupus erythematosus syndrome. **Endocrine:** Gynecomastia, hypoglycemia. **Cardiovascular:** Arrhythmias. **Renal:** Decreased creatinine clearance, polyuria, azotemia.

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J9AR13

The author looks at the history of health care delivery and discusses its implications for present and future access to quality health care.

The Effects of the Evolution of the Health Care System on the Problems of Health Systems Access, Cost, and Quality

JAMES W. HOLSINGER JR., M.D., F.A.C.P., *Augusta**

PERHAPS IT IS NOT unreasonable to state that the underlying cause of the health system problems of access, cost, and quality lies with the uncertainty that surrounds the definition of health itself. In 1946, the World Health Organization defined health as "... a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity."[1] No wonder our society is unsure of what it expects from its health care system, since such a far reaching definition places all of society under the aegis of health care. It is easy to postulate that no health care system could provide the care required to reach the goals implicit in this definition, and in all likelihood, no society could afford its cost. Therefore, in order to rationally attempt to consider the problems of health systems access, cost, and quality, an attainable definition of health must be devised. Otherwise our society will continue to chase the chimera of unattainable expectations. In this paper, Kass's definition of health will be used, in which "health is a natural standard or norm — not a 'value' as opposed to an obligation — but a state of being that reveals itself in activity as a standard of bodily excellence or fitness, relative to each species and to some extent attainable."[2] Thus, health is the well-working of the organism as a whole, referring to the individual, not the society in which he lives.

The problem of access into the health system has developed out of evolution of the expectations of the society itself as well as the evolution of the physician within society. As society evolved and various roles became differentiated, the physician-priest came into being as the individual in society who could deal with some of the unknowns of life. Eventually, the two functions separated and traditionally, the physician began to deal with those things that concerned the health of the society. The physician emerged to provide cure, while the family continued to care for the individual. As long as the family provided the care of the individual, access into the health care system did not pose a major difficulty. Following the advent of the hospital as it is known today, around the beginning of the 20th century, the care of the individual was found to be better carried out by professionals who practiced within its setting. With the transfer of the responsibility for patient care out of the home and into the institution, the control of access into the system was likewise transferred from the patient and his family to the institution. As the exponential generation of new scientific facts occurred, especially after the First World War, the physician found that he possessed an ever increasing ability to change the course of disease. As more information became available to him, it became apparent that initially 2 and then 4 years of medical education were insufficient to produce a physician capable of assimilating, as well as being able to put to use, the knowledge available. This led to the

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development of post-graduate medical education programs and the development of specialization. As 20th century medical care has continued to evolve, subspecialization has closely followed the development of specialization. With the expanding role of the specialist and the diminishing of the role and authority of the general practitioner, access into the health care system has become increasingly complex. Although American society has retained its love for the general practitioner, it has compounded the problem of its own access into the system by demanding that care, especially in times of crisis, be provided by a specialist or subspecialist. All too frequently is heard the plaintive cry of, "Don't you think he should see a cardiologist?" or, "Who's the best surgeon in town?"

With the transfer of the responsibility for patient care out of the home and into the institution, the control of access into the system was likewise transferred from the patient and his family to the institution.

A further problem of access has occurred with the development of the concept that health and/or medical care is a right. As the care of the individual passed from the family to the institution, the financial ability of the patient to pay for the services provided became inadequate. In the early days of the hospital, philanthropy played a major role in reducing or at least defraying the cost of medical care for the patient. However, as the scientific aspects of medical care evolved during the past 50 years, the hospital became the repository of costly technology. The costs of the new technologies outstripped the ability of the individual or the philanthropist to pay.

In order to protect himself against the cost of health care, as well as to insure that his financial situation would not act as a bar to access into the system, the individuals banded together to spread the risk of the cost of illness by purchasing insurance, thus providing the funds to enter the system. As the concept developed that health or health care is a right of every citizen, other third party payors appeared, notably the government in the form of Medicare and Medicaid. Although the combination of third party payment systems covers all but about 6 million Americans,[3] this has not in and of itself solved the problem of access to health care. Instead, it has produced demands on the system that cannot be met within the apparent resources that can be committed to health care. Thus, between the expectations of society produced through the mechanism of third party payment and the expectations of physicians as determined by their desire to specialize, access into the health care system remains an unresolved problem.

The evolution of the health care system has had a direct impact on the cost of delivering health care. It now costs approximately $737 per capita for health care in the United States.[3] This amounted to $162.6 billion in 1977, representing 8.8% of the Gross National Product (GNP).

As 20th century medicine has evolved in the United States, a certain false expectation has been created that the physician can cure not only physiologic impairments but that he can and should be able to cope with all kinds of problems, "including the prevention of crime, the taming of juvenile delinquents, the relief of poverty and racial discrimination, the reduction of laziness and philandering, and the rearing of decent and moral men and women."[2] It is no wonder, then, that this expansion of the health "needs" of our society in conjunction with the development of the concept of the "right to health and/or medical care" has produced the marked rise in the cost of delivering health care over the past 25 years.

Even with the historic increase in the number of physicians and other health care professionals in the last 10 years, the supply of health care providers has not been able to keep up with the increase in demand generated by society. In 1978, nearly twice as many physicians graduated from our medical schools as graduated in 1964.[4] In the past, the U.S. government has increased its subsidy for medical education through the use of capitation grants, as well as underwriting the cost of building new medical schools and expanding old ones. As the cost of health care as a percent of the GNP has increased, it is estimated that each physician who goes into practice creates an increase of $300,000 per year in additional health care costs.[4] On this basis, the former Secretary of the Department of Health, Education, and Welfare, Joseph Califano Jr., called for a reduction in new physicians. It is anticipated that capitation grants will cease in the near future.[4]

The combination of third party payment systems covers all but about 6 million Americans.

In conjunction with questions concerning the supply side of the equation, demand as represented by the preferences and desires of individuals and society has continued to rise. With a reduction in the out-of-pocket expense to the individual as determined by the combination of health care insurance and other medical benefit plans, financial barriers to health care for most individuals in our society have decreased, resulting in a vastly increased demand. The effect of the costs of new technology has been at least arithmetically additive if not geometrically. Thus, the problem of the cost of health care leads almost

directly to the question of quality — are we helped or hurt by what we are paying so much for as a society?

The cost of health care in the United States has increased from $10 billion in 1950 to $163 billion in 1977.[3] Yet there has been no quantum leap in anti-infectious technology since 1950, and the current list of the most common major diseases is nearly identical to that of 1950.[5] What then in the way of additional health or quality of life does the outlay of approximately $130 billion per year above the level of 1950 (allowing for inflation) purchase for our society? A person reaching age 65 today can only expect to live 2.2 years longer than his grandfather who reached age 65 in 1900.[6] The annual physical examination has not been shown to be cost effective, nor is there evidence that it either prolongs life or improves the quality of life. In fact, the evidence is strong that the health care system has not even been responsible for the increase in life expectancy or for the increase in quality of life that has occurred in this century.

It has been estimated that well over half of the visits to American physicians are due to deviations from health for which the patient, or his way of life, is in some important way responsible.

More than half the reduction in mortality rates over the past 3 centuries occurred before 1900, and this was due to the effects of the improvements in our way of life resulting from technologic advances, overall levels of education, and public health measures. Even half of the 2.2 years of additional life expectancy which has occurred since 1900 can be found prior to 1970.[6] By and large, the major improvements in health have resulted from changes in personal behavior (hygiene, reproductive practices) and in environmental conditions (food supplies, provision of safe milk and water, and sewage disposal). Knowles[7] states, that "over 99% of us are born healthy and made sick as a result of personal misbehavior and environmental conditions." It is difficult to hold the health care system responsible for the effects of our way of life upon our health. It has been estimated that well over half of the visits to American physicians are due to deviations from health for which the patient, or his way of life, is in some important way responsible. Knowles has stated that "the greatest portion of our national expenditure (for health care) goes for the caring of the major causes of premature, and therefore preventable, death and/or disability."[7] As he states, we cannot hope to develop a rational health system if the parts of the whole that bear on health are moving in irrational ways.

A continuation of the rising demand for the consumption of health care services will simply add to the burdens on our health care system. There is an obvious need to articulate and delimit the domain and the responsibilities of the health care system. This will also entail a realization that health is, in different ways, everyone's business — each of us responsible for his own health. It is of more than passing interest that the solution to many of the problems of our health care system may be relieved by simply avoiding its use. Breslow's seven rules may do more to produce a healthy population than a visit to the doctor.*

* They are (1) Don't smoke cigarettes, (2) Get 7 hours of sleep, (3) Eat breakfast, (4) Keep your weight down, (5) Drink moderately, (6) Exercise daily, and (7) Don't eat between meals.[8]

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NATIONAL HEALTH SERVICES CORPS:

The National Health Service Corps (NHSC) was established by the Emergency Health Personnel Act in 1970 authorizing the U.S. Public Health Service, for the first time in its history, to meet the health needs of underserved civilian populations. With a history of service to groups such as American Indians, merchant marines, and federal prisoners, this was the first time federally employed physicians could provide medical services to the general population.

In 1977, the National Health Professions Education Assistance Act significantly changed the NHSC Scholarship Program.[1] First, it broadened the methodology for defining the health manpower shortage areas, enlarging those included by this definition to almost 1200 counties, census tracts, trade areas, and neighborhoods who were thus eligible for NHSC assistance. Second, it expanded the size of the scholarship program significantly and increased the authorization for the program. Third, it mentioned state mental hospitals and prison facilities as appropriate placement for NHSC members, for the first time involving them in institutional work. Fourth, it changed the buy-out provisions of the program. Specifically, the new buy-out provisions would require a scholarship recipient to pay back in excess of $30,000 per year of scholarship received in order to fulfill the scholarship obligation. For those who have a scholarship for the entire 4 years of medical school, the buy-out would be in excess of $120,000; consequently, only a few would be able to select this option. Thus, the changes in the law have, since 1977, (1) added new geographic areas to those eligible for NHSC assistance; (2) significantly increased the size of the program in terms of number of scholarships; (3) added the possibility of institutional services; and (4) made the buy-out option an extremely expensive one.

The impact of this new scholarship program is being noticed and will become even more noticeable in the early 1980's. The rise in field strength of this group of health professionals is apparent from recently available data.[2] The NHSC field strength is now 1,504, of whom 47% are physicians. This number is double that of the autumn of 1977, with the aim of 2,820 professionals by the fall of 1980. The field strength of the program is planned to grow to approximately 8,000 in 1985. President Carter's budget request for FY 1980 would allow for 6,195 students to be supported (4,708 continuations and 1,487 new scholarships).[3]

Translated into regional and state terms, the impact is even more striking. The Southeast DHEW Region IV, consisting of eight states, has the largest percentage of counties which are designated as medically underserved. Of the approximate 1,500 NHSC scholarship recipients that will be available per year in the mid 1980's, Region IV will in all likelihood be eligible for 400-500 physicians. If divided equally among the eight southeastern states in Region IV, Georgia would receive as many as 40 to 60 NHSC volunteers per year. This large number of new physicians who are committed to work in underserved areas (either urban or rural)

will include a number of native Georgians, many of whom will represent minority groups, women, and physicians who have 4-year scholarship commitments to fulfill. Most scholarship recipients will have specialty training beyond internship and many will be Board Eligible. Specialty representation includes approximately 25% in family practice, 15% in internal medicine, and 15% in pediatrics. Thus, the medical profession will be faced with the important challenge of assuring proper utilization and placement of these physicians.

The medical profession is faced with the important challenge of assuring proper placement and utilization of a significant source of physician manpower.

There are currently three opportunities in the NHSC placement process for the medical community to have input into the proper utilization of NHSC physicians. The first opportunity is at the time of designation of a county, census tract, trade area, or neighborhood as a Critical Manpower Shortage Area. This designation occurs via an application to the Health Systems Agency, which in turn reviews the application and designates the area as meeting pre-determined criteria. The second opportunity for input occurs when a community, which has been designated as a Critical Manpower Shortage Area, makes application for designation as a NHSC site. This application is forwarded to local medical societies for comment. The application is also reviewed by the Health Systems Agency and comment by local medical societies at the time of that review is also appropriate. The third opportunity for input occurs when a physician is placed at the NHSC site. These NHSC physicians cannot function appropriately without being integrated into the local medical community. When they visit a prospective community to select a site, the feedback that the local medical community provides is of considerable importance with regard to their decision to select that community and ultimately with regard to their willingness to remain after their service obligation is fulfilled.

At this time, the mechanisms for significant input into local NHSC activities are not clearly known or used by physicians. With the potential influx of such a large number of new physicians through this program, it will be essential that local and state medical communities use existing channels of input with a greater sense of importance over the next few years. It is also incumbent upon the medical communities at both the state and local levels to use their influence and ingenuity to develop new ways of impacting on decisions with regard to the NHSC, in an effort to secure the best services and most appropriate utilization of this new manpower for the people in the state of Georgia.

M. Julian Duttera Jr., M.D.
Chairman, Access to Health Care Committee
LaGrange

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2. Ibid.
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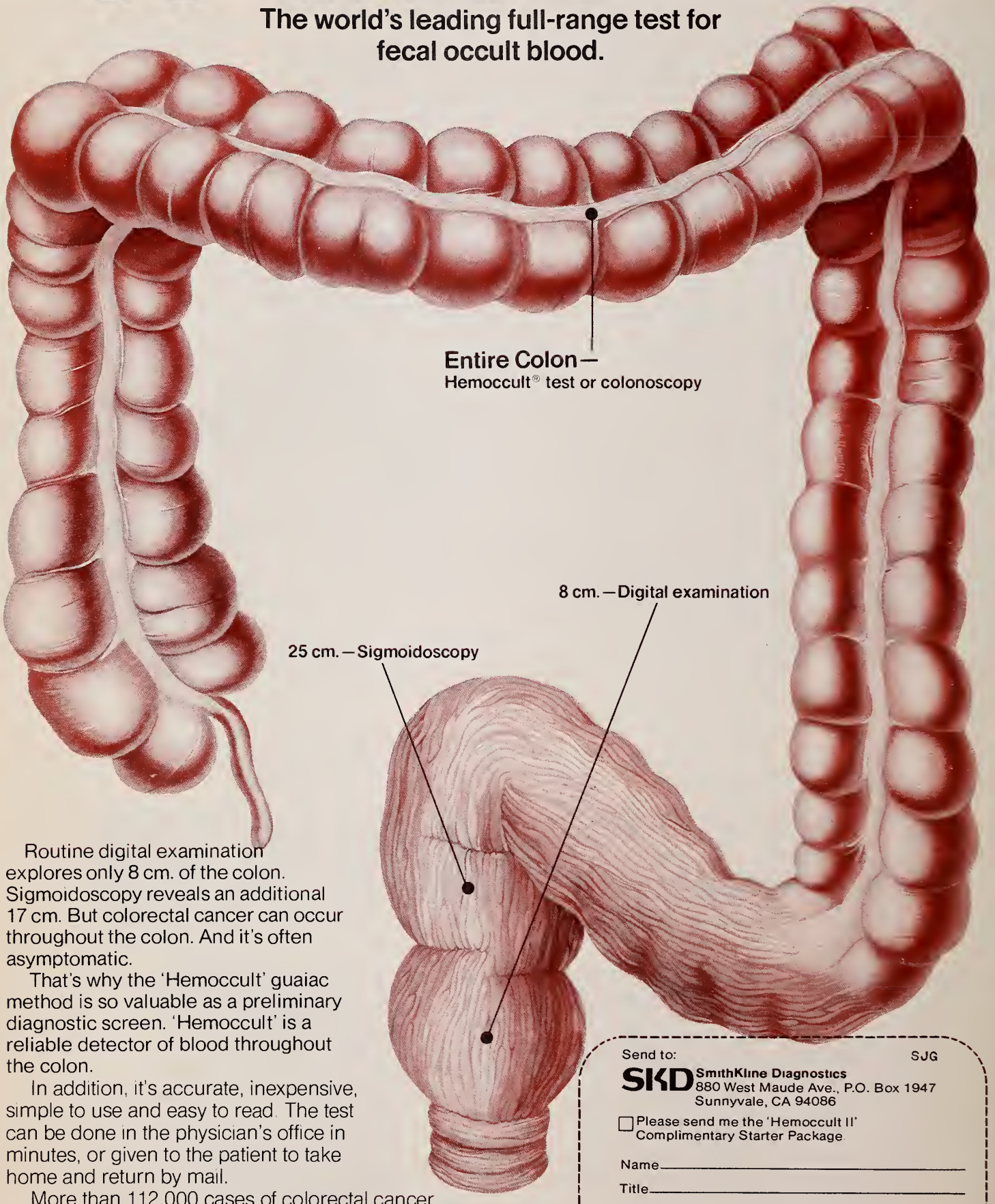
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Dr. John D. Rogers v. the Medical Association of Georgia, the Composite State Board of Medical Examiners, and Governor George D. Busbee — An Update

ROBERT CONNELLY, *Atlanta**

In the "Legal Page" featured in the September 1979 issue of the *Journal,* it was reported that Dr. John D. Rogers had instituted a civil lawsuit against the Medical Association of Georgia (MAG), The Composite State Board of Medical Examiners (Board), and Governor George D. Busbee, challenging the constitutionality of a Georgia statute which established the manner in which members of the Board are appointed. As noted in the earlier article, the trial court upheld the constitutionality of the law, and Dr. Rogers appealed the case to the Supreme Court of Georgia. Since then, **the Supreme Court has issued an opinion in which it ruled that the statute is unconstitutional.** This ruling has substantial implications not only for the manner of appointments to and the membership of the Board but also for the manner of appointments to and the composition of other significant state regulatory boards.

The Decision

The statute which was nullified by the Supreme Court is Ga. Code Ann. §84-903. This law provided that the 10 members of the Board must be duly licensed M.D.'s and must be chosen by the Governor from a list of not less than three and not more than five qualified candidates for each position submitted to him by the MAG. The statute also required that the Governor's nominees must be approved by the Georgia Senate. Dr. Rogers' constitutional arguments were three-fold. He contended that: (1) he had been denied rights secured to him by the equal protection clauses of the Georgia Constitution and the Fourteenth Amendment to the United States Constitution; (2) he had been denied rights secured to him by the due process clauses of the Georgia Constitution and the Fourteenth Amendment to the United States Constitution; and (3) the statute unconstitutionally delegated powers to the MAG which are inherently those of the Governor. The Supreme Court did not pass on the first two arguments, but rather struck the statute down on the third ground suggested by Dr. Rogers.

After rejecting the argument of the MAG that Dr. Rogers had not been injured by the operation of the statute and, therefore, lacked standing to sue, the Supreme Court held that Ga. Code Ann. §84-903 effects an unconstitutional delegation to a private organization the power to appoint public officials. In reaching this conclusion, the Supreme Court stated:

> These constitutional provisions [Ga. Code Ann. §§2-201, 2-202 and 2-1401] mandate that public affairs shall be managed by public officials who are accountable to the people. As important as any other governmental power is

* Prepared at the request of the Medical Association of Georgia. Mr. Connelly is an associate in the firm of Powell, Goldstein, Frazer, & Murphy, General Counsel to the Association, 1100 C & S National Bank Building, Atlanta, GA 30303.

the power to appoint public officials. They are the persons who control so much of our lives. The importance of this power is emphasized by the constitutional provision by which the people initially granted to their Chief Executive, the Governor, the power to fill vacancies in public offices "unless otherwise provided by law; and persons so appointed shall continue in office until a successor is commissioned, agreeably to the mode pointed out by this Constitution or by law in pursuance thereof." Code Ann. §2-2804. In our opinion, it is clear that the constitutional provisions cited above demand that the power to appoint public officers remain in the public domain. The General Assembly may, within constitutional limitations, establish qualifications for public office and designate a governmental appointing authority. But it cannot delegate the appointive power to a private organization. Such an organization, no matter how responsible, is not in the public domain and is not accountable to the people as our constitution requires. It represents and is accountable to its membership. Here the Medical Association of Georgia, a private organization, controls the appointment of the members of the State Board of Medical Examiners under the 1971 Act which provides that the Governor must appoint from its nominees. This is violative of our Constitution.

In concluding that Ga. Code Ann. §84-903 is unconstitutional, the Supreme Court did not, however, oust from office the present members of the Board. The Court reasoned that they were properly qualified, duly appointed, and not charged with any misconduct. Under the Supreme Court's formulation, only future appointments to the Board need not be limited to those persons recommended by the MAG.

Implications of the Decision

The one point which is clear from the Supreme Court's decision is that the Governor is not required to look solely to the MAG for recommendations for Board members. The decision does not foreclose the possibility of the MAG suggesting people for appointment, but the Governor is no longer constrained to limit his selections to those persons nominated by the MAG.

The ruling of the Supreme Court acknowledged that the General Assembly may, within constitutional limitations, establish qualifications for those people who are appointed to the Board; however, the Supreme Court did not intimate what kinds of legislatively established qualifications are permissible. In view of the Supreme Court's statements in this regard and in view of the fact that after the Supreme Court's decision, there is no statute governing the manner of making appointments to the Board, new legislation in this regard may be introduced during the 1980 session of the Georgia General Assembly. In order to provide the Governor with some guidance as to what training and experience Board members should possess, the legislation may establish certain minimum professional qualifications for membership on the Board.

In addition to voiding Ga. Code Ann. §84-903, the Supreme Court ruling casts doubt on the validity of several Georgia statutes which prescribe the manner by which individuals are nominated for and appointed to other important regulatory boards in Georgia. These boards include the Georgia Board of Dentistry,[1] the Board of Veterinary Medicine,[2] the Georgia Board of Nursing,[3] the State Board of Examiners of Psychologists,[4] the Georgia Board of Chiroprctors,[5] the State Board of Registration for Professional Geologists,[6] and the Board of Examiners on Speech Pathology and Audiology.[7] Rather than waiting until lawsuits are filed which challenge the means of making appointments to these boards, it is possible that the Georgia legislature will amend these statutes to conform to the *Rogers* decision.

Notes

1. Ga. Code Ann. §84-702.
2. Ga. Code Ann. §84-1504.
3. Ga. Code Ann. §84-1002.
4. Ga. Code Ann. §84-3103.
5. Ga. Code Ann. §84-503.
6. Ga. Code Ann. §84-2114a.
7. Ga. Code Ann. §84-6704.

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Cardiovascular Disease Death Rates for Counties in Georgia

CURTIS G. HAMES, M.D., F.A.C.C., *Claxton*, and HERBERT I. SAUER, M.S.P.H., *Columbia, MO**

Introduction

From 1950 through 1959, counties in north Georgia had the lowest rates in the state for deaths due to cardiovascular disease among white men aged 35-74 (age-adjusted).[1] Many counties in the coastal plain and nearby had very high death rates. Some questions which come to mind regarding these facts include: What are the geographic patterns for more recent years? What are the recent trends in death rates?

Materials and Methods

For the years 1968-1976 inclusive, tapes detailing causes of death were obtained from the National Center for Health Statistics. Each person who died was tabulated by county of usual residence, cause of death, age, sex, and race. The revised Census population tape for 1970, obtained through the Institute for Behavioral Research, University of Georgia, and estimates for more recent years directly from the Bureau of the Census, provided the population at risk for calculating death rates.

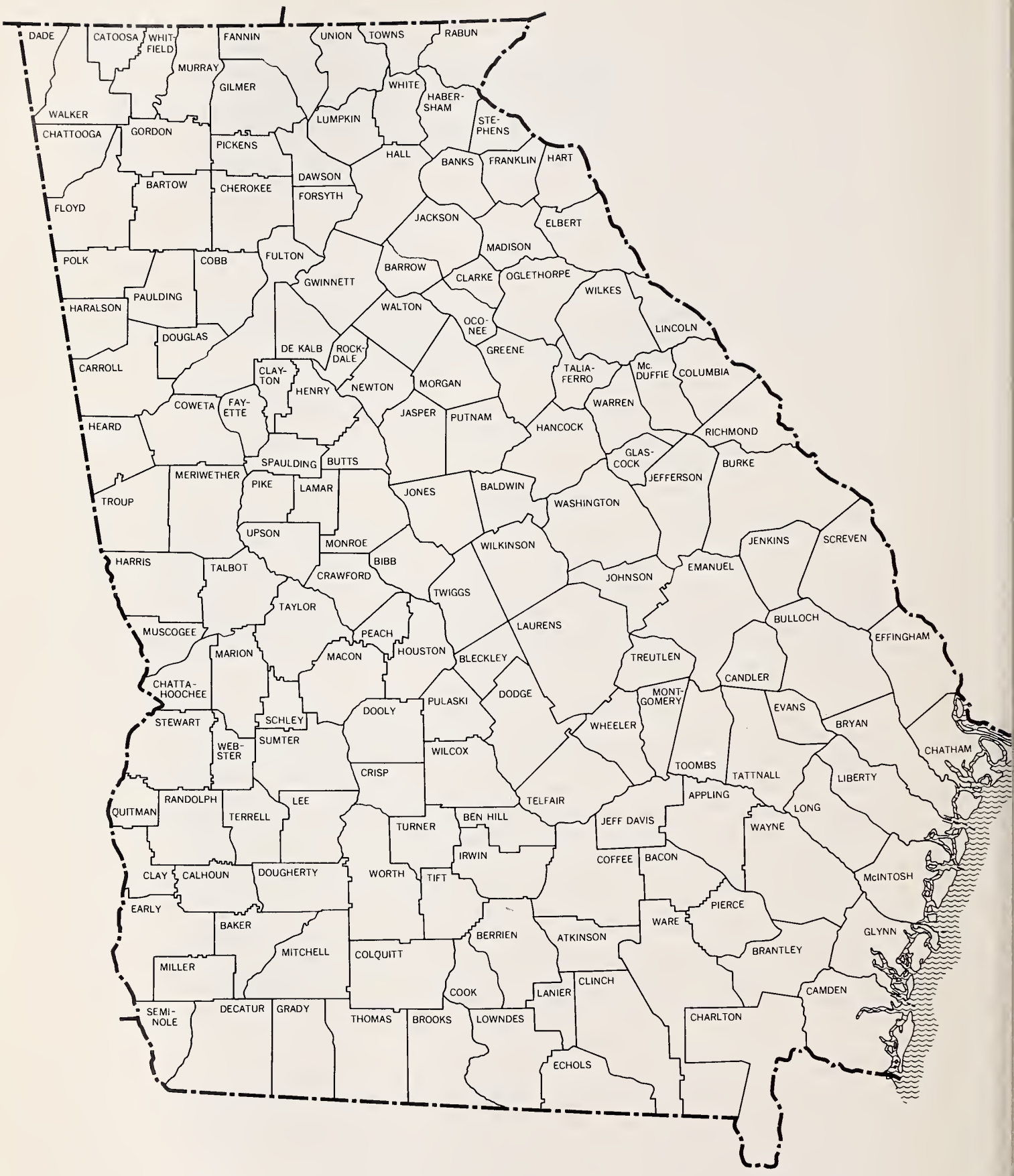
Attention was given to epidemiologic and demographic methods presented in a recent report[2] in the calculation and analyses of these rates. Deaths classified as due to ill-defined symptoms or conditions were included in the cardiovascular disease group, because of evidence that this would produce less error in calculating the rates than assuming that none of these deaths fell in this group. For Georgia, however, the decision made in this regard had little effect upon patterns. All death rates are presented as average annual death rates per 100,000 estimated population at risk.

Patterns by County

For the 1968-1976 period, only 15 of Georgia's 159 counties had death rates for cardiovascular disease less than the national United States rate of 772, even though in the 1950's, 40% of Georgia's counties had rates lower than the national rate. The counties with low death rates were concentrated in the northeastern Georgia portion of the Blue Ridge Mountains, with a few in the Atlanta area.

For the period 1968-1976, 36 counties had rates at least 300 points (40%) higher than the United States rate, while in the 1950's, only five counties had rates proportionately as high. These counties with very high death rates were again all in

* Dr. Hames practices internal medicine in Claxton. Mr. Sauer is a Research Associate at the University of Missouri. Direct reprint requests to Mr. Sauer, Research Associate, University of Missouri, 11 Professional Bldg., Columbia, MO 65201. Articles for this page are prepared at the request of the Physician Education Committee of the American Heart Association, Georgia Affiliate, Broadview Plaza, Level C, 2581 Piedmont Rd., NE, Atlanta, GA 30324.



State of Georgia by County

Map produced by American Map Co.

the coastal plain or nearby. The concentration of high-rate counties is greatest in a triangular area roughly delineated by the cities of Macon and Augusta and by Charlton County (near Jacksonville, Florida). In the 1968-1972 period, of the 100 counties with the highest death rates due to cardiovascular disease in the United States, 30 were in Georgia.[2]

From the 1950's to the 1968-1976 period, the national rate for cardiovascular diseases declined about 11%. Compared to this, the counties of Georgia present mixed trends. Less than half of the metropolitan counties showed a decline, with Savannah-Chatham county having the greatest decrease. Fulton, DeKalb, and Richmond counties also showed substantial decreases. Even so, all but one of the metropolitan counties had rates higher than the national rate. The non-metropolitan counties showed similarly mixed patterns — less than half showed a decline in rates, while only 14 had rates less than the United States.

For the middle 1970's (1973-1976), all of metropolitan counties had decreases, as compared with the period 1968-1972, while 62 of the non-metropolitan counties showed increases.

Discussion

Many of the Georgia counties have very small populations, and therefore allowance needs to be made for the role of chance fluctuation, especially for non-metropolitan counties. Even so, it appears that many counties in Georgia are not following the national trend. We do not know the reasons either for the national decline in death rates due to cardiovascular diseases or for the high rates in many Georgia counties. A basis for searching for factors responsible, however, consists of two characteristics of Georgia death rate patterns: (1) Death rates for men are often 3 to 4 times as great as for women for cardiovascular disease in middle-aged whites, whereas in parts of the northeastern United States, men's rates are only twice as high. (2) Rates for cancer, especially cancer other than respiratory, tend to be below average, often much lower than average, in spite of the high cardiovascular disease rates.

Further identification of clear patterns of this type will assist in developing and testing hypotheses concerning the causes for the high rates in Georgia counties. We are proposing the possibility that deficiencies in selenium or other minerals may in some way be contributing to the high rates. Many other factors both in the physical-biological environment and in the cultural environment also require consideration. If physicians in practice or others have suggestions as to possible causes, we shall be glad to participate in the effort to test such suggestions.

Acknowledgement

Acknowledgement is given for the assistance of Lynn E. Reed and Richard D. Curd, and to partial support from the University of Missouri-Columbia Development Fund and contract HRA 230-7B-0002, National Center for Health Statistics.

References

1. Sauer HI, Payne GH, Council CR, Terrell JC: Cardiovascular diseases mortality patterns in Georgia and North Carolina. Pub Health Reps 1966; 81:455-465.

2. Geochemistry and the Environment. Vol. III, National Academy of Sciences, 1978, pp. 121-125.



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President, MAG

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PERSONALS

First District

William Watkins, M.D., formerly of Dublin, has ended his retirement and opened a practice in Dudley.

Second District

Jacob L. Shirley Jr., M.D., of Albany, was recently elected vice chairman of the State Medical Education Board.

Fourth District

Harvey Sacks, M.D., of Atlanta, has opened an office in the Braly Medical Building in Dallas, Georgia.

Fifth District

After 11 years of service to St. Joseph's Hospital, **William F. Friedewald, M.D.,** has retired as Chief of Staff. The prominent physician was honored with a dinner and two receptions prior to leaving the hospital. The hospital has named **Napier Burson, M.D.,** gastroenterologist, as Acting Chief of Staff effective immediately.

William E. Huger, M.D., of Atlanta, was recently elected President of the Southeastern Society of Plastic and Reconstructive Surgeons at the Society's annual meeting at Sea Island, Georgia.

Seventh District

Joseph G. Bussey Jr., M.D., F.A.C.S., of Austell, attended the American Pain Society Meeting in San Diego September 9-12. Dr. Bussey presented a paper entitled, "Post-Surgical Tens Analgesia: A Retrospective Comparison of Transcutaneous Electrical Nerve Stimulation With Standard Post-Surgical Analgesic (IM) Therapy."

David A. Wells, M.D., of Dalton, was recently elected chairman of the State Medical Education Board.

SOCIETIES

The **Bibb County Medical Society** sponsored a Health Seminar on September 17 at the Macon Coliseum. Macon physicians George Henry, M.D., Jack Menendez, M.D., and William J. O'Shaughnessy, M.D., presented 15-minute talks on stress, exercise, and nutrition, then fielded questions from the audience.

DEATHS

Frederick Eugene Sims

Frederick Eugene Sims, M.D., aged 60, died Thursday, June 28. Dr. Sims was a native of Covington and had lived in Albany 17 years. He was a member of Covenant Presbyterian Church in Albany and a past elder in the Dawson Presbyterian Church. He was a member of the American Medical Association, Southern Medical Association, the Medical Association of Georgia, the American Society of Family Practice, American Society of Anesthesiologists, and the Dougherty Medical Society. He also served on the executive board of the Phoebe Putney Memorial Hospital.

Survivors include his wife, one daughter, and three sons.

New Specialties Recognized

The AMA has recently recognized additional specialties not listed in the *Roster* and MAG's Interspecialty Council has agreed that MAG would uniformly recognize those recognized by AMA. The 13 are:

ADL — Adolescent Medicine
AL — Allergy & Immunology
BLB — Bloodbanking
DMP — Dermatopathology
MSF — Maxillofacial Surgery
NPM — Neonatal-Perinatal Medicine
NA — Neuropathology
NR — Nuclear Radiology
OT — Otology
PDE — Pediatric Endocrinology
PHO — Pediatric Hematology-Oncology
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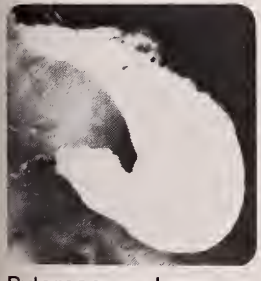
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†See Warnings, Precautions and Adverse Reactions.

See following page for prescribing information.

Reference:
King, J.C. and Starkman, N.M.: Evaluation of an antispasmodic. Double-blind evaluation to control gastrointestinal spasms occurring during radiographic examination. A preliminary report. Western Med. 5:356-358, 1964.

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Final classification of the less-than-effective indications requires further investigation.

CONTRAINOICATIONS: Obstructive uropathy (for example, bladder neck obstruction due to prostatic hypertrophy); obstructive disease of the gastrointestinal tract (as in achalasia, pyloroduodenal stenosis); paralytic ileus, intestinal atony of the elderly or debilitated patient; unstable cardiovascular status in acute hemorrhage; severe ulcerative colitis; toxic megacolon complicating ulcerative colitis; myasthenia gravis. WARNINGS: In the presence of a high environmental temperature, heat prostration can occur with drug use (fever and heat stroke due to decreased sweating). Oiarrhea may be an early symptom of incomplete intestinal obstruction, especially in patients with ileostomy or colostomy. In this instance treatment with this drug would be inappropriate and possibly harmful. Bentyl may produce drowsiness or blurred vision. In this event, the patient should be warned not to engage in activities requiring mental alertness such as operating a motor vehicle or other machinery or perform hazardous work while taking this drug. PRECAUTIONS: Although studies have failed to demonstrate adverse effects of dicyclomine hydrochloride in glaucoma or in patients with prostatic hypertrophy, it should be prescribed with caution in patients known to have or suspected of having glaucoma or prostatic hypertrophy. Use with caution in patients with: Autonomic neuropathy. Hepatic or renal disease. Ulcerative colitis. Large doses may suppress intestinal motility to the point of producing a paralytic ileus and the use of this drug may precipitate or aggravate the serious complication of toxic megacolon. Hyperthyroidism, coronary heart disease, congestive heart failure, cardiac arrhythmias, and hypertension. Hiatal hernia associated with reflux esophagitis since anticholinergic drugs may aggravate this condition.

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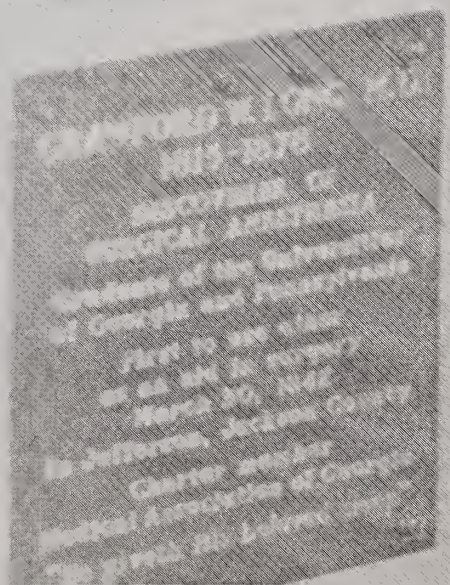
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Crawford W. Long Museum Reopens in Jefferson, Georgia



Dr. E. L. Frederickson, Chairman of MAG's Crawford W. Long Memorial Committee, and host of the rededication ceremonies. Dr. Frederickson is Professor of Anesthesiology and Pharmacology, Emory University School of Medicine.

ONE OF THE HIGHLIGHTS in the history of Georgia medicine was Dr. Crawford W. Long's first use of sulfuric ether as an anesthetic during surgery. Georgia's renowned native son was again honored Sept. 30, 1979, at the rededication of the museum bearing his name in Jefferson, Georgia. E. L. Frederickson, M.D., Professor of Anesthesiology and Pharmacology at Emory University School of Medicine, and Chairman of MAG's Crawford W. Long Museum Committee, hosted the ceremonies. Dr. Frederickson and his committee were responsible for spearheading MAG's involvement in the redecoration and refurbishment of the museum. MAG President Earnest C. Atkins, M.D., was on hand for remarks after which Mr. Frary Elrod, President of the Crawford W. Long Museum Association, Dr. Atkins, and Carl A. Smith, M.D., President of the Georgia Society of Anesthesiologists cut the ribbon to officially reopen the museum.



Mr. and Mrs. Frary Elrod with the latest addition to the museum, a reprint of a woodcut depicting Dr. Long's first surgery using sulfuric ether. Mr. Elrod is President of the Crawford W. Long Museum Association.



(From L to R): Dr. Carl Smith, President Georgia Society of Anesthesiologists, Mr. Frary Elrod, President of the Crawford W. Long Museum Association, and Dr. Earnest Atkins, President of the Medical Association of Georgia, cut the ribbon for the rededication.



One of the display cases at the museum featuring surgeon's equipment (saws) from the 19th century. Hanging on the wall to the right is a pardon from U.S. President Andrew Johnson absolving Dr. Long from punishment for his participation in the War Between the States.

The museum was first opened in 1957 by the MAG and with the assistance of grants from the state. It is now owned and operated by the City of Jefferson, which is located 55 miles northeast of Atlanta (4 miles from Interstate 85). Patsy A. Gerstner, Ph.D., Curator of the Howard Dittrick Museum of Historical Medicine, Cleveland, Ohio, designed, specified, and supervised the renovation of the museum. Mr. Richard Frank, M.A., did the construction of the displays under Dr. Gerstner's supervision.

The displays present developments in anesthesiology from 1850 to the present day. The original diorama of Dr. Long's now famous surgery, in which he first used sulphuric ether as an anesthetic, is a featured exhibit. Other exhibits offer interesting insight into both Dr. Long's life as a physician and the mid-19th century in which he lived.

The latest addition to the museum is a reprint of a woodcut depicting Dr. Long's first surgery using sulfuric ether as an anesthetic. John Steinhaus, M.D., Chairman of the Anesthesiology Department at Emory University, presented it to Mr. and Mrs. Frary Elrod during the rededication ceremonies.

Classifieds

RATES AND DATA: Space in this section is sold on a per-word basis as follows: **Members**—$5.00 for the first 50 words; $.10 per word for each additional word. **Non-members**—$15.00 for the first 50 words; $.10 per word for each additional word. *Charges are payable in advance.* Copy must be typed and received by the Publisher no later than the 12th of the month preceding publication. Blind box numbers are available at an additional charge of $1.00 per insertion. For more information, contact the Managing Editor at 938 Peachtree St., NE, Atlanta, Ga. 30309, telephone (404) 876-7535, INWATS in Georgia (800) 282-0224.

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Indications and Usage: For the treatment of urinary tract infections due to susceptible strains of the following organisms: *Escherichia coli, Klebsiella-Enterobacter, Proteus mirabilis, Proteus vulgaris, Proteus morganii.* **It is recommended that initial episodes of uncomplicated urinary tract infections be treated with a single effective antibacterial agent rather than the combination.** *Note:* The increasing frequency of resistant organisms limits the usefulness of all antibacterials, especially in these urinary tract infections.

Also for the treatment of documented *Pneumocystis carinii* pneumonitis. To date, this drug has been tested only in patients 9 months to 16 years of age who were immunosuppressed by cancer therapy.

The recommended quantitative disc susceptibility method (*Federal Register,* 37:20527-20529, 1972) may be used to estimate bacterial susceptibility to Bactrim. A laboratory report of "Susceptible to trimethoprim-sulfamethoxazole" indicates an infection likely to respond to Bactrim therapy. If infection is confined to the urine, "Intermediate susceptibility" also indicates a likely response. "Resistant" indicates that response is unlikely.

Contraindications: Hypersensitivity to trimethoprim or sulfonamides; pregnancy; nursing mothers; infants less than two months of age.

Warnings: Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been associated with sulfonamides. Experience with trimethoprim is much more limited but occasional interference with hematopoiesis has been reported as well as an increased incidence of thrombopenia with purpura in elderly patients on certain diuretics, primarily thiazides. Sore throat, fever, pallor, purpura or jaundice may be early signs of serious blood disorders. Frequent CBC's are recommended; therapy should be discontinued if a significantly reduced count of any formed blood element is noted.

Precautions: Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, severe allergy or bronchial asthma. In patients with glucose-6-phosphate dehydrogenase deficiency, hemolysis, frequently dose-related, may occur. During therapy, maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function.

Adverse Reactions: All major reactions to sulfonamides and trimethoprim are included, even if not reported with Bactrim. *Blood dyscrasias:* Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia. *Allergic reactions:* Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis. *Gastrointestinal reactions:* Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, diarrhea and pancreatitis. *CNS reactions:* Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness. *Miscellaneous reactions:* Drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L. E. phenomenon. Due to certain chemical similarities to some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia in patients; cross-sensitivity with these agents may exist. In rats, long-term therapy with sulfonamides has produced thyroid malignancies.

Dosage: Not recommended for infants less than two months of age.

Urinary Tract Infections: Usual adult dosage—1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 10-14 days.

Recommended dosage for children—8 mg/kg trimethoprim and 40 mg/kg sulfamethoxazole per 24 hours, in two divided doses for 10 days. A guide follows:

Children two months of age or older:

Weight		Dose—every 12 hours	
lbs	kgs	Teaspoonfuls	Tablets
20	9	1 teasp. (5 ml)	½ tablet
40	18	2 teasp. (10 ml)	1 tablet
60	27	3 teasp. (15 ml)	1½ tablets
80	36	4 teasp. (20 ml)	2 tablets or 1 DS tablet

For patients with renal impairment:

Creatinine Clearance (ml/min)	Recommended Dosage Regimen
Above 30	Usual standard regimen
15-30	½ the usual regimen
Below 15	Use not recommended

Pneumocystis carinii pneumonitis: Recommended dosage: 20 mg/kg trimethoprim and 100 mg/kg sulfamethoxazole per 24 hours in equal doses every 6 hours for 14 days. See complete product information for suggested children's dosage table.

Supplied: *Double Strength (DS) tablets,* each containing 160 mg trimethoprim and 800 mg sulfamethoxazole, bottles of 100; Tel-E-Dose® packages of 100. *Tablets,* each containing 80 mg trimethoprim and 400 mg sulfamethoxazole—bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 40, available singly and in trays of 10. *Oral suspension,* containing in each teaspoonful (5 ml) the equivalent of 40 mg trimethoprim and 200 mg sulfamethoxazole, fruit-licorice flavored—bottles of 16 oz (1 pint).

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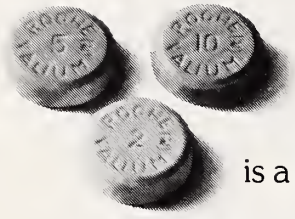
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Valium (diazepam/Roche) is a benzodiazepine with a character all its own. Pharmacologically, it is a potent skeletal muscle relaxant and anticonvulsant (in adjunctive use), as well as an antianxiety agent. Pharmacokinetically, only Valium provides active *diazepam* as well as the active metabolites 3-hydroxydiazepam, desmethyldiazepam and oxazepam.

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Another important aspect of the clinical character of Valium is safety. Though drowsiness, ataxia and fatigue are possible, these and more serious side effects are rarely a problem. Of course, as with all CNS-acting drugs, patients taking Valium should be cautioned against driving, operating dangerous machinery or the simultaneous ingestion of alcohol.

Unquestionably, many psychotherapeutic agents, including other benzodiazepines, have antianxiety effects. But one fact remains: you get a certain kind of patient response with Valium. It's a response you want. A response you know. A response you trust as part of your overall management of anxiety and psychic tension.

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Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology; spasticity caused by upper motor neuron disorders; athetosis; stiff-man syndrome; convulsive disorders (not for sole therapy).

The effectiveness of Valium (diazepam/Roche) in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

Usage in Pregnancy: **Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

Dosage: Individualize for maximum beneficial effect. *Adults:* Tension, anxiety and psychoneurotic states, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. *Geriatric or debilitated patients:* 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) *Children:* 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

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COVER

Our cover illustration this month is from an old wood cut. It is such a beautiful, tender depiction of love, which is the subject of our editorial on p. 1067. Cover design by Richard Lyons of Richard Heiman Advertising, Inc.

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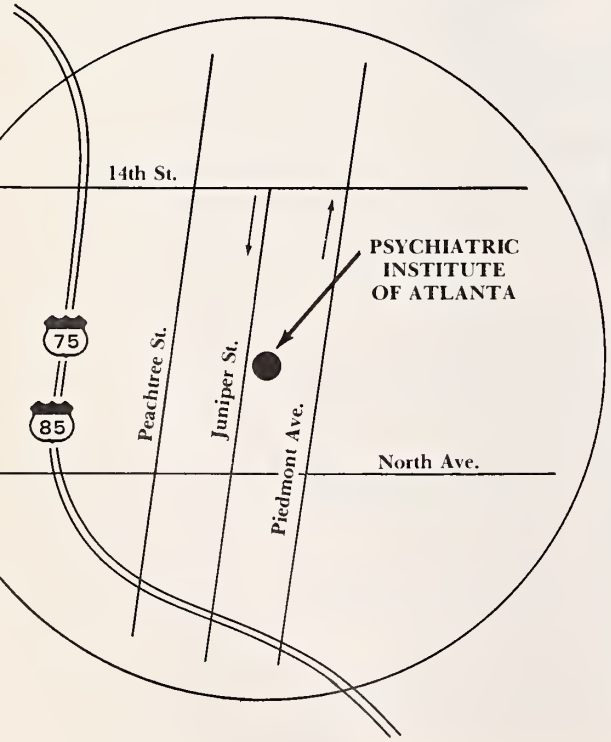
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13-19—*Acapulco, Mexico;* **PEDIATRICS IN REVIEW—1980—THE SCHOOL-AGE CHILD;** Contact: Judson Hawk Jr., M.D., Scottish Rite Hospital for Crippled Children, 1001 Johnson Ferry Rd., N.E., Atlanta 30342. PH: 404/256-5252.

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23-24—*Augusta;* **MEETING, GEORGIA AND SOUTH CAROLINA SOCIETIES OF ANESTHESIOLOGISTS;** Contact: William T. Freeman, M.D., Medical College of Georgia, Augusta 30912. PH: 404/828-3871.

28-March 1—*Gainesville, FL;* **7TH ANNUAL SELECTED TOPICS IN UROLOGY;** Category 1 credit; Contact: Bill Rockwood, Box J-233, J. Hillis Miller Health Center, Gainesville, FL 32610. PH: 904/392-3143.

29-March 1—*Birmingham, AL;* **MKSAP: HEMATOLOGY, CARDIOVASCULAR DISEASES, PULMONARY DISEASES, NEPHROLOGY;** Contact: Jaan Kangilaski, American College of Physicians, 4200 Pine St., Philadelphia, PA 19104. PH: 215/243-1200.

MARCH

1-8—*Steamboat Springs, CO;* **FIFTH ANNUAL SNOW JOB IN GYNECOLOGY AND OBSTETRICS;** Category 1 credit; Contact: Associate Dean for CME, Emory University School of Medicine, 69 Butler St., S.E., Atlanta 30303. PH: 404/588-3534.

2-9—*Caribbean Sea;* **ONCOLOGY IN GENERAL PRACTICE;** Category 1 credit; Sponsored by University of Miami School of Medicine; Contact: Peter W. A. Mansell, M.D., Clinical Cancer Education Program, Centre House, PH-E, 1400 N.W. 10th Ave., Miami, FL 33136. PH: 305/547-6103.

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9-15—*Orlando, FL;* **AMERICAN SOCIETY OF CONTEMPORARY OPHTHALMOLOGY;** Contact: R. Howard, M.D., 6 N. Michigan Ave., Room 1110, Chicago, IL 60602.

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31-April 4—*Kissimmee, FL;* **11TH FAMILY PRACTICE REVIEW;** Category 1 credit; Contact: Bill Rockwood, Box J-233, J. Hillis Miller Health Center, University of Florida College of Medicine, Gainesville, FL 32610. PH: 904/392-3143.

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They called us Father Feeney's Fighting Fools. A rag-tag collection of country kids rounded up by the Padre. The only requirement for joining his athletic club was an almost insane devotion to the sport of football.

Father Feeney kept the team going on donations. Since the area was pretty poor, we mostly played with a lot of heart and practically no equipment. For instance, each player was supposed to furnish his own football shoes. Turned out I was the only guy on the team who couldn't afford any. So Moose Wozniak good-naturedly allowed me to share his. Moose's shoes weren't any too swanky to start with, being hand-me-downs from his big brother, but they served the purpose.

Moose'd come hobbling off the field and unlace. I'd slip into his shoes and dash back out. Only problem was Moose wore a size 12. I wore size 9. So I had to stuff the toes with paper. Then I'd spend all my time on the field with my toes butted up against wadded newspapers. All my life I remembered that sensation.

And all my life I remembered the team. And the man who taught me the game, and that life has its goals, too. When I got my first job, he was the one who advised me to join the Payroll Savings Plan. And those U.S. Savings Bonds been growing ever since.

One thing I did was set aside a portion of those Bonds to pay back an old debt. Finally, I was able to send Father Feeney a big donation. Along with a note that said: "Father, make sure everybody has a pair of football shoes . . . and make sure everybody has the right size."

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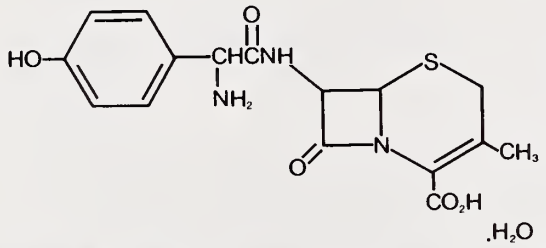
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DURICEF®

(CEFADROXIL MONOHYDRATE)

References:
1. Data on file, Mead Johnson Pharmaceutical Division.
2. Gatley MS: To be taken as directed. *J Ray Coll Gen Pract* 16:39, 1968.

DESCRIPTION: DURICEF® (cefadroxil monohydrate) is a semisynthetic cephalosporin antibiotic intended for oral administration. It is a white to yellowish-white crystalline powder. It is soluble in water and it is acid-stable. It is chemically designated as 7-[[D-2-amino-2-(4-hydroxyphenyl)acetyl]amino]-3-methyl-8-oxo-5-thia-1-azabicyclo [4.2.0]oct-2-ene-2-carboxylic acid monohydrate. It has the following structural formula:



Clinical Pharmacology–DURICEF (cefadroxil monohydrate) is rapidly absorbed after oral administration. Following single doses of 500 and 1000 mg., average peak serum concentrations were approximately 16 and 28 mcg./ml., respectively. Measurable levels were present 12 hours after administration. Over 90 percent of the drug is excreted unchanged in the urine within eight hours. Peak urine concentrations are approximately 1800 mcg./ml. during the period following a single 500 mg. oral dose. Increases in dosage generally produce a proportionate increase in DURICEF urinary concentration. The urine antibiotic concentration, following a 1 gm. dose, was maintained well above the MIC of susceptible urinary pathogens for 20 to 22 hours.

MICROBIOLOGY: *In vitro* tests demonstrate that the cephalosporins are bactericidal because of their inhibition of cell-wall synthesis. DURICEF is active against the following organisms *in vitro:*

Beta-hemolytic streptococci
Staphylococci, including coagulase-positive, coagulase-negative, and penicillinase-producing strains
Streptococcus (Diplococcus) pneumoniae
Escherichia coli
Proteus mirabilis
Klebsiella species

Note–Most strains of *Enterococci (Streptococcus faecalis* and *S. faecium)* are resistant to DURICEF. It is not active against most strains of *enterobacter species, P. morganii,* and *P. vulgaris.* It has no activity against *Pseudomonas* or *Herella species.*

Disc Susceptibility Tests–Quantitative methods that require measurement of zone diameters give the most precise estimates of antibiotic susceptibility. One recommended procedure (CFR Section 460.1) uses cephalosporin class disc for testing susceptibility; interpretations correlate zone diameters of the disc test with MIC values for DURICEF. With this procedure, a report from the laboratory of "resistant" indicates that the infecting organism is not likely to respond to therapy. A report of "intermediate susceptibility" suggests that the organism would be susceptible if the infection is confined to the urinary tract, as DURICEF produces high antibiotic levels in the urine.

INDICATIONS: DURICEF (cefadroxil monohydrate) is indicated for the treatment of the following infections when caused by susceptible strains of the designated microorganisms:

Urinary tract infections caused by *E. coli, P. mirabilis,* and *Klebsiella* species

Skin and skin structure infections caused by staphylococci and/or streptococci

Note–Culture and susceptibility tests should be initiated prior to and during therapy. Renal function studies should be performed when indicated.

CONTRAINDICATION: DURICEF (cefadroxil monohydrate) is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

WARNING: IN PENICILLIN-ALLERGIC PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE USED WITH GREAT CAUTION. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS, AND THERE ARE INSTANCES OF PATIENTS WHO HAVE HAD REACTIONS TO BOTH DRUGS (INCLUDING FATAL ANAPHYLAXIS AFTER PARENTERAL USE.)

Any patient who has demonstrated a history of some form of allergy, particularly to drugs, should receive antibiotics cautiously and then only when absolutely necessary. No exception should be made with regard to DURICEF (cefadroxil monohydrate).

PRECAUTIONS: Patients should be followed carefully so that any side-effects or unusual manifestations of drug idiosyncrasy may be detected. If a hypersensitivity reaction occurs, the drug should be discontinued and the patient treated with the usual agents (e.g., epinephrine or other pressor amines, antihistamines, or corticosteroids).

DURICEF (cefadroxil monohydrate) should be used with caution in the presence of markedly impaired renal function (creatinine clearance rate of less than 50 ml/min/1.73M²). (See Dosage and Administration.) In patients with known or suspected renal impairment, careful clinical observation and appropriate laboratory studies should be made prior to and during therapy.

Prolonged use of DURICEF may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs test may be due to the drug.

USAGE IN PREGNANCY: Although no teratogenic or anti-fertility effects were seen in reproductive studies in mice and rats receiving dosages greater than the normal human dose, the safety of this drug for use in human pregnancy has not been established. The benefits of the drug in pregnant women should be weighed against a possible risk to the fetus.

ADVERSE REACTIONS: Gastrointestinal–The most frequent side-effect has been nausea. It was infrequently severe enough to warrant cessation of therapy. Administration with food decreases nausea and does not decrease absorption. Diarrhea and dysuria have also occurred.

Hypersensitivity–Allergies (in the form of rash, urticaria, and angioedema) have been observed. These reactions usually subsided upon discontinuation of the drug.

Other reactions have included genital pruritus, genital moniliasis, vaginitis, and moderate transient neutropenia.

DOSAGE AND ADMINISTRATION: DURICEF (cefadroxil monohydrate) is acid stable and may be administered orally without regard to meals. Administration with food may be helpful in diminishing potential gastrointestinal complaints occasionally associated with oral cephalosporin therapy.

Adults–For urinary tract infections the usual adult dosage is one gm. (two 500 mg. capsules) two times per day. For skin and skin structure infections the usual dose is 500 mg. two times per day or 1 gm. once a day.

In patients with renal impairment, the dosage of cefadroxil should be adjusted according to creatinine clearance rates to prevent drug accumulation. The following schedule is suggested. In adults, the initial dose is 1 gm. of DURICEF (cefadroxil monohydrate) and the maintenance dose (based on the creatinine clearance rate [ml/min/1.73M²]) is 500 mg. at the time intervals listed below.

Creatinine Clearances	Dosage Interval
0-10 ml/min	36 hours
10-25 ml/min	24 hours
25-50 ml/min	12 hours

Patients with creatinine clearance rates over 50 ml/min may be treated as if they were patients having normal renal function.

Children–Dosage and safety have not yet been established in children.

HOW SUPPLIED: DURICEF® (cefadroxil monohydrate) capsules 500 mg. for oral administration in an opaque maroon cap and opaque white body No. 0 hard gelatin capsule. On each half capsule printed in black is "MJ" and "500." Available in bottles of 24 capsules (NDC 0087-0784-41) and 100 capsules (NDC 0087-0784-42).

U.S. Patent Re. 29,164

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Selected Cardiac Problems in the Elderly Patient

NANETTE K. WENGER, M.D., *Atlanta**

Introduction

THE ELDERLY cardiac patient may present with the traditional cardiac problems encountered in all age groups — hypertensive cardiovascular disease, coronary atherosclerotic heart disease, rheumatic heart disease, luetic heart disease, cardiomyopathy, etc. However, three cardiac problems, seen with increased frequency in the aged population, will be emphasized in this presentation. The first two are diagnosed by the presence of a cardiac murmur — calcific aortic stenosis of a bicuspid or a tricuspid aortic valve; and mitral regurgitation, due either to myxomatous degeneration of the mitral valve or to mitral annular calcification. Patients with these problems may present with varying severity of chest pain syndromes, congestive heart failure, dysrhythmias, etc., and are also prone to infective endocarditis. The third is the problem of management and surveillance of the patient requiring pacemaker implantation.

Calcific Aortic Stenosis

This abnormality occurs more commonly in men, increases with advancing age, and involves the aortic valve leaflets as well as the aortic annulus. As previously mentioned, calcification may occur in a normal tricuspid aortic valve or, more frequently, in a congenitally bicuspid aortic valve. It is thought to be due to the trauma of years of valve function. Fat droplets initially appear in the valvular connective tissue, and calcification progressively follows. The calcification occurs predominantly in the valve leaflet base, on the aortic side. Thus the valve leaflets remain moderately mobile and the commissures unfused.

The symptoms of hemodynamically significant aortic stenosis include angina pectoris, congestive heart failure, and syncope. Because these symptoms may be due to coronary atherosclerotic heart disease, hypertensive cardiovascular disease, cerebral vascular disease, etc., and because clinical examination offers little reliability in assessing the severity of aortic stenosis, diagnostic cardiac catheterization is mandatory when these symptoms develop in an elderly patient with a murmur of aortic stenosis. Exercise testing should not be performed in patients suspected of having severe aortic stenosis, since these patients are at increased risk. Because of their inability to increase their cardiac output with exercise, effort syncope may occur. Remember, too, that complete heart block may result from extension of the aortic valvular or annular calcification into the interventricular septum.

Noninvasive procedures are of little value in assessing the hemodynamic significance of this lesion. Palpation of the carotid pulse offers no reliable clue to the severity of aortic outflow obstruction in the elderly patient; the rigid carotid vessels of the aged individual may mask the characteristic slowly-rising carotid pulse of severe aortic stenosis. Perhaps the only clinical clue to severity is that a diastolic blood pressure consistently greater than 100 mm Hg virtually excludes hemodynamically significant aortic stenosis.

Because the unfused valve leaflets move separately, an aortic ejection click does not occur. Atrial (S4) sounds are virtually always heard in elderly patients, hence they offer no specific diagnostic value. The onset of atrial fibrillation, with loss of the "atrial kick" provided by regular sinus rhythm, may precipitate congestive heart failure. The systolic murmur, ausculted at the base (in the second right intercostal space) may be the typically harsh and noisy murmur of aortic stenosis; however, a musical cooing murmur is often heard at the cardiac apex.

* Dr. Wenger is Professor of Medicine (Cardiology), Emory University School of Medicine, and Director, Cardiac Clinics, Grady Memorial Hospital. Address reprint requests to Dr. Wenger at 69 Butler St., SE, Atlanta, GA 30303. This paper was presented at the American Women's Medical Association Meeting, November, 1978.

This latter murmur may be confused with the murmur of a calcified mitral annulus, a problem which may, indeed, coexist in some elderly patients.

The electrocardiogram in the patient with significant aortic stenosis is one of left ventricular systolic overload. Regular sinus rhythm or atrial fibrillation may be present. The presence of atrial fibrillation does not, as in the younger patient, suggest the coexistence of mitral valve disease. Cardiac enlargement on chest x-ray is unusual without coexisting disease or heart failure, but aortic post-stenotic dilatation is common. At fluoroscopy, in the LAO view, calcification is seen in the middle third of the cardiac silhouette, higher in position than mitral valve calcification (Figure 1). Echocardiography demonstrates decreased systolic excursion of the aortic valve leaflets, and the calcific valve leaflet echoes have a greater density than the aortic wall echoes (Figure 2).



Figure 1 — Chest x-ray showing aortic valvular calcification (arrow).

Mitral Annular Calcification

Mitral annular calcification is common in the elderly patient, particularly the elderly woman. In contrast to aortic valve calcification, it rarely involves the mitral valve leaflets; but it may also extend into the interventricular septum and cause conduction disturbances, including complete heart block.

This problem is typically asymptomatic and is identified either by calcification detected on a chest roentgenogram or by the auscultation of a cardiac murmur. This murmur is generally a Grade II-III spindle-shaped apical holosystolic murmur; at times,

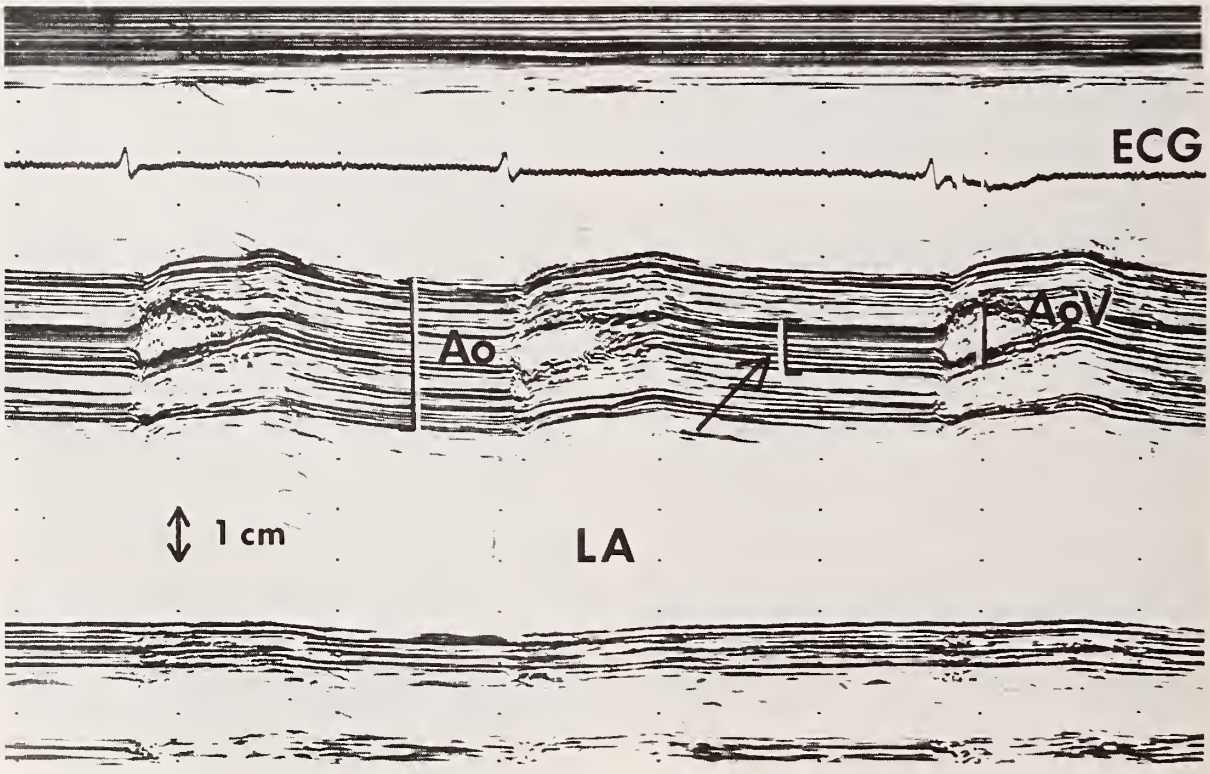


Figure 2 — Arrow indicates dense echoes compatible with aortic valve calcification. Ao = aorta; AoV = aortic valve. Note decreased leaflet excursion and leaflet thickening; LA = left atrium.

as previously discussed, it may be confused with the apical murmur of aortic stenosis or, indeed, may coexist with calcific aortic stenosis.

Diagnosis is best made at fluoroscopy, where a J-, U-, or O-shaped homogeneous pattern of calcification is seen in the posterior third of the cardiac silhouette on the lateral or LAO view (Figure 3). Echocardiography is confirmatory, identifying the dense annular calcific echoes (Figure 4).

Clinically, it is imperative that these typically minimally symptomatic patients and their physicians appreciate the need for endocarditis prophylaxis.

Myxomatous Degeneration of the Mitral Valve

Myxomatous degeneration of the mitral valve, which may occur at any age but is not uncommon in the aged patient, may cause a variably prolapsing mitral valve leaflet. Thus, a mid-to-late systolic click and a late apical systolic murmur, as well as, at times, multiple systolic clicks, may be appreciated. When the patient stands, or when amyl nitrate is inhaled (both of these maneuvers decreasing the size of the left ventricular cavity), mitral leaflet prolapse occurs earlier, and both the click and murmur increase in intensity and are heard earlier (Figure 5).

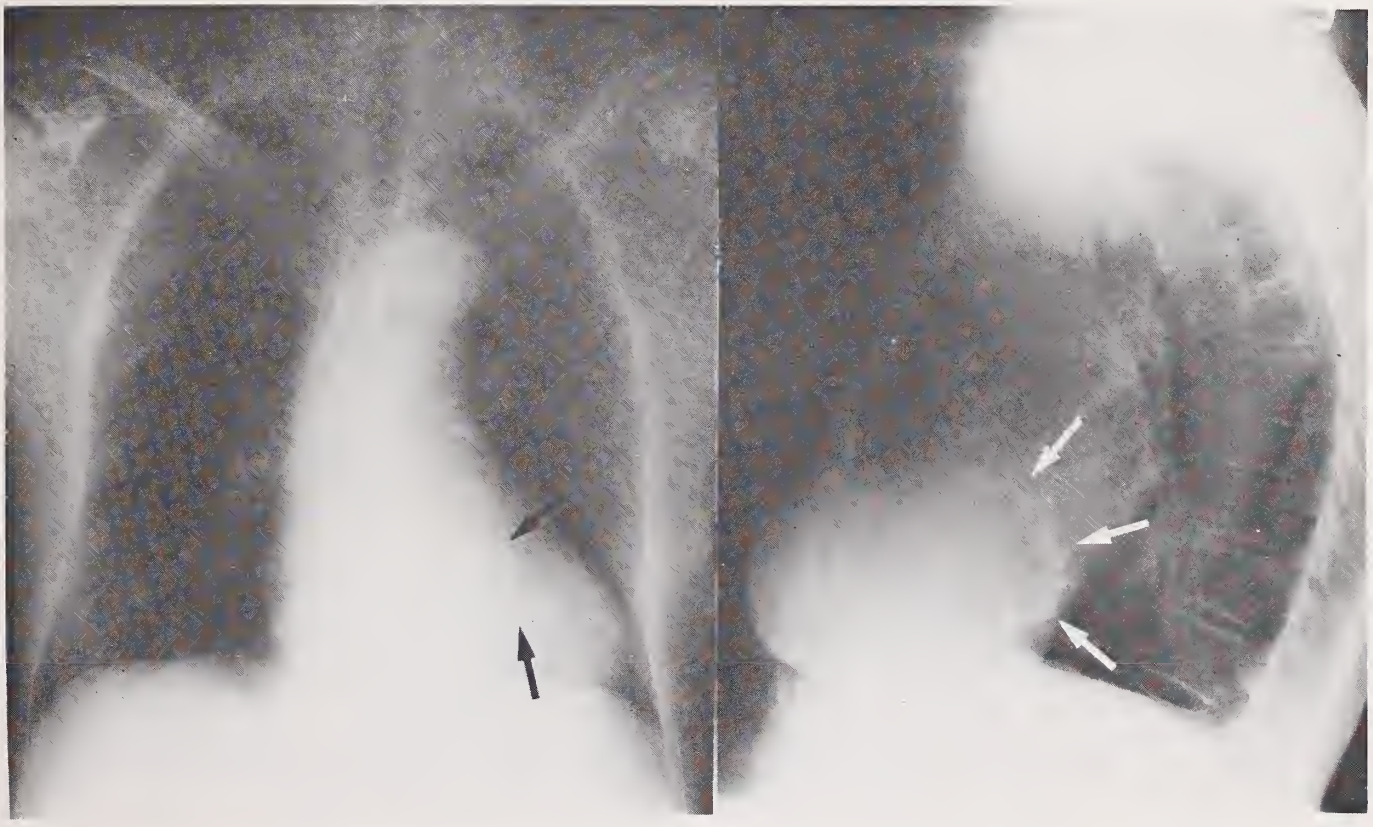


Figure 3 — X-ray showing mitral annulus calcification (arrow).

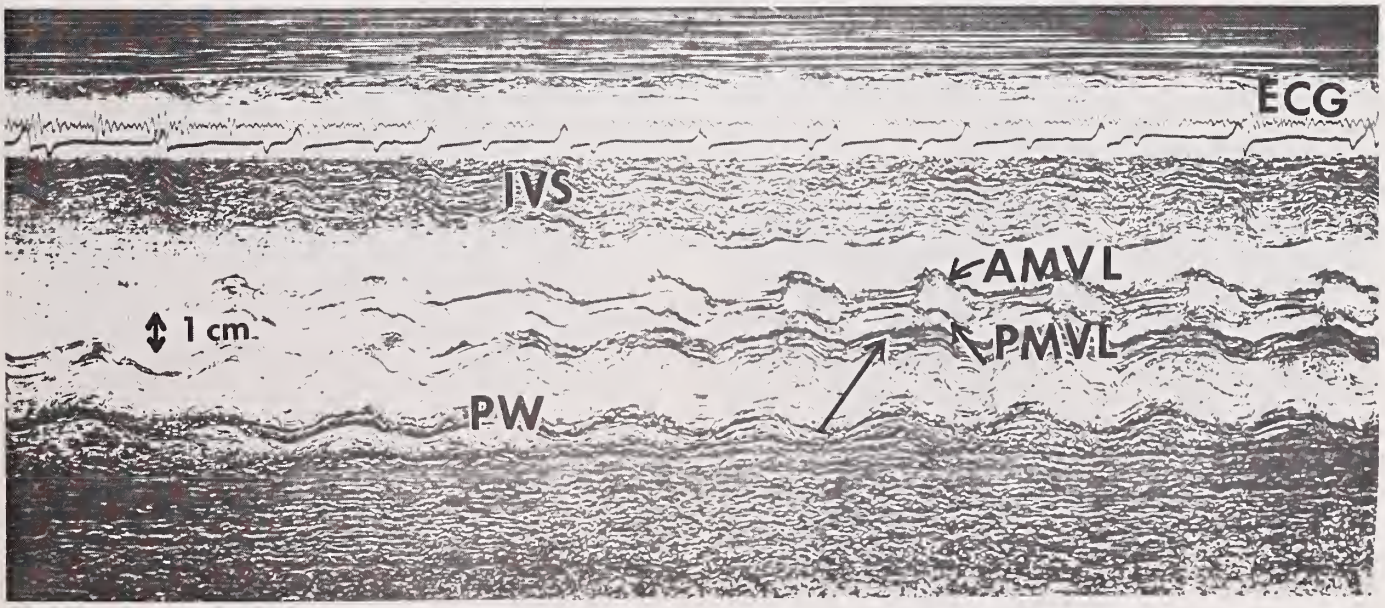


Figure 4 — Dense echoes (arrow) reflecting mitral annular calcification. IVS = interventricular septum; PW = posterior left ventricular wall; AMVL = anterior mitral valve leaflet; PMVL = posterior mitral valve leaflet.

Maneuvers which increase the systemic blood pressure, such as handgrip, also increase the intensity of the murmur. Echocardiography is confirmatory, demonstrating systolic prolapse of the mitral leaflet (Figure 6).

Hemodynamically significant mitral regurgitation, a heart failure syndrome, may require valve replacement if not amenable to medical therapy, such as digitalis, diuretic drugs, vasodilator therapy. At times, secondary mitral valve leaflet calcification may occur and be visible on chest film. Chordal rupture may be associated with the onset of severe acute mitral regurgitation, necessitating urgent mitral valve replacement. Endocarditis prophylaxis is mandatory.

Implanted Cardiac Pacemakers

The final problem to be discussed is the elderly patient who requires an implanted cardiac pacemaker, either for complete heart (atrioventricular) block or for the sick sinus syndrome. This advance in patient management, which has substantially enhanced survival, requires surveillance to insure that the pacemaker continues to function properly.

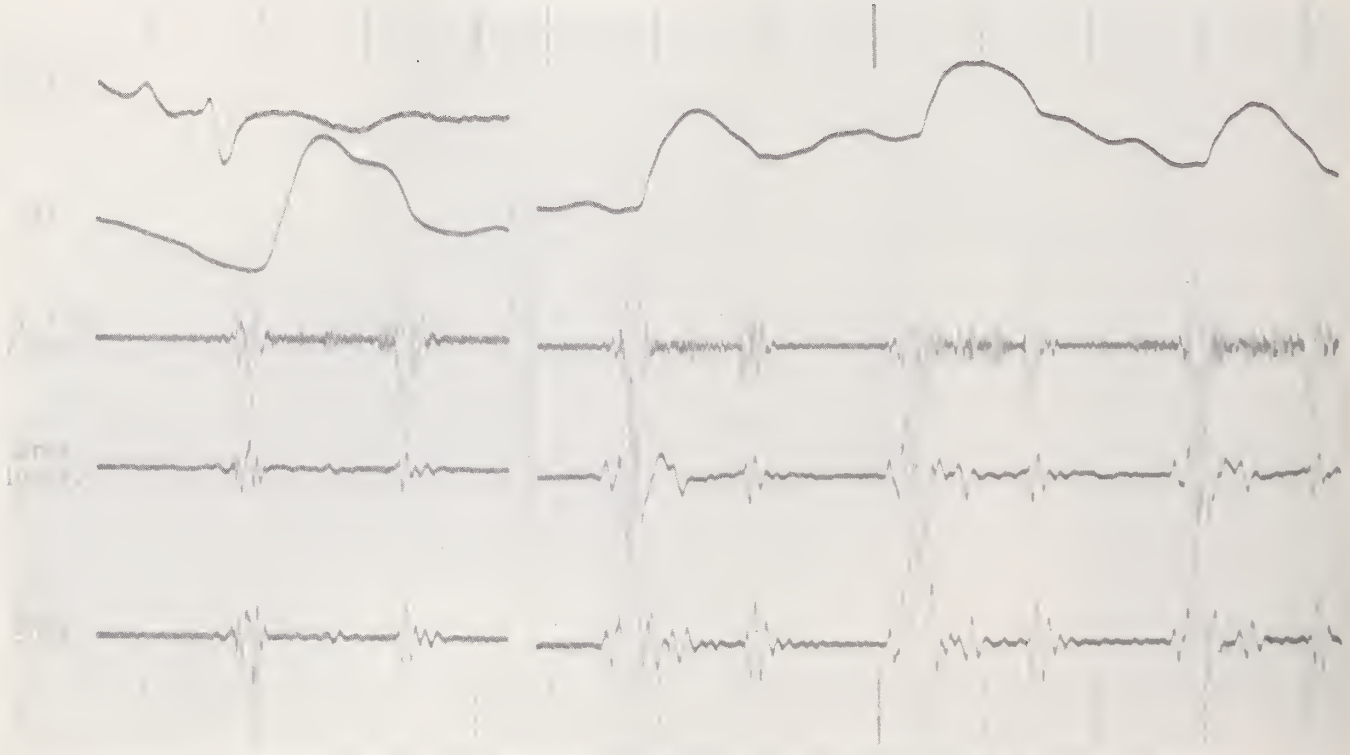


Figure 5 — Phonocardiogram of mitral valve prolapse before and after the inhalation of amyl nitrite. See text.

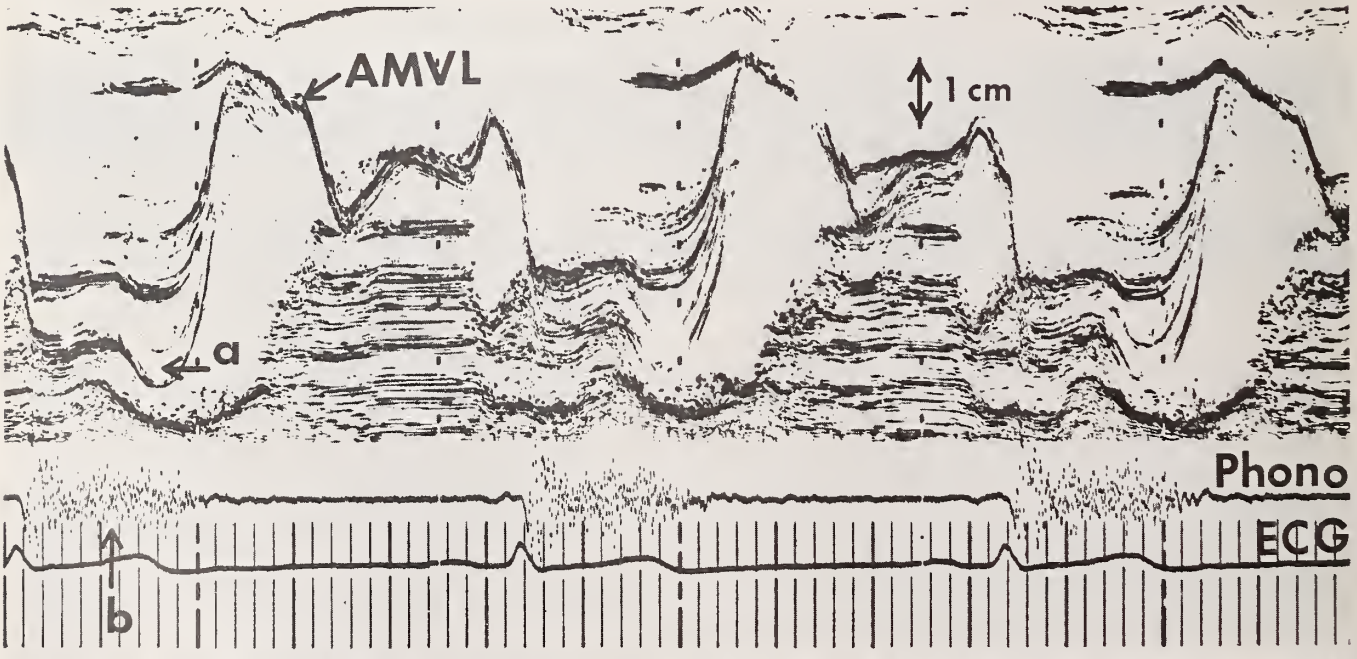


Figure 6 — "a" shows mid-systolic posterior motion of the posterior mitral valve leaflet, diagnostic of mitral valve prolapse. "b" shows the holosystolic murmur of mitral valve prolapse. AMVL = anterior mitral valve leaflet.

Complete heart block, which may result from myocardial infarction; from a degenerative process in the cardiac fibrous skeleton; or which may be related to calcification of the septum extending from aortic or mitral valvular or annular calcification, requires pacemaker management only when associated with hemodynamic compromise. This includes the heart block associated with syncope or alteration of consciousness, with angina pectoris, or with the onset of significant congestive heart failure.

The sick sinus syndrome is characterized by sinus bradycardia, prolonged sinus pauses, and episodes of sinus arrest or sinoatrial block; it may or may not be associated with myocardial infarction. Because of the bradycardia, the patient commonly describes fatigue, lightheadedness, dizziness, and syncope. Congestive heart failure may supervene. Some patients with the sick sinus syndrome also have the bradycardia-tachycardia syndrome, i.e., intermittent recurrent episodes of both bradycardia and tachycardia, usually supraventricular tachycardia. Although the underlying bradycardia, per se, may not produce significant hemodynamic alterations, drugs used to suppress the tachyarrhythmias may sufficiently slow the sinus bradycardia that pacemaker therapy is required to permit use of suppressive therapy for the tachyarrhythmias.

Let me review some background information about pacemaker components which is necessary to appreciate the modes of surveillance of pacemaker function. A cardiac pacemaker consists of electrodes, connected by insulated wires to a power source or generator; the generator contains, in addition to the power cells, complex sensing and pacing circuits (Figures 7 A & B).

The ventricular inhibited pacemaker, the most commonly used model today, is programmed to fire at a rate of 75 beats per minute, i.e., an RR interval of 800 msec. If the patient's intrinsic heart rate has an RR interval less than 800 msec. (a heart rate greater than 75 beats per minute), the pacemaker senses the patient's cardiac impulses and does not fire. When the pacemaker fails to sense the patient's intrinsic ventricular rhythm, after an interval of 800 msec., it fires to pace the heart.

Either of two types of electrodes may connect the power source to the myocardium. Endocardial or transvenous electrodes are inserted via the venous system onto the right ventricular endocardium (Figure 7A). Epicardial placement of electrodes requires thoracotomy for direct implantation onto the left ventricle (Figure 7B).

Although wire breakage and, occasionally, increased resistance at the site of electrode implanta-

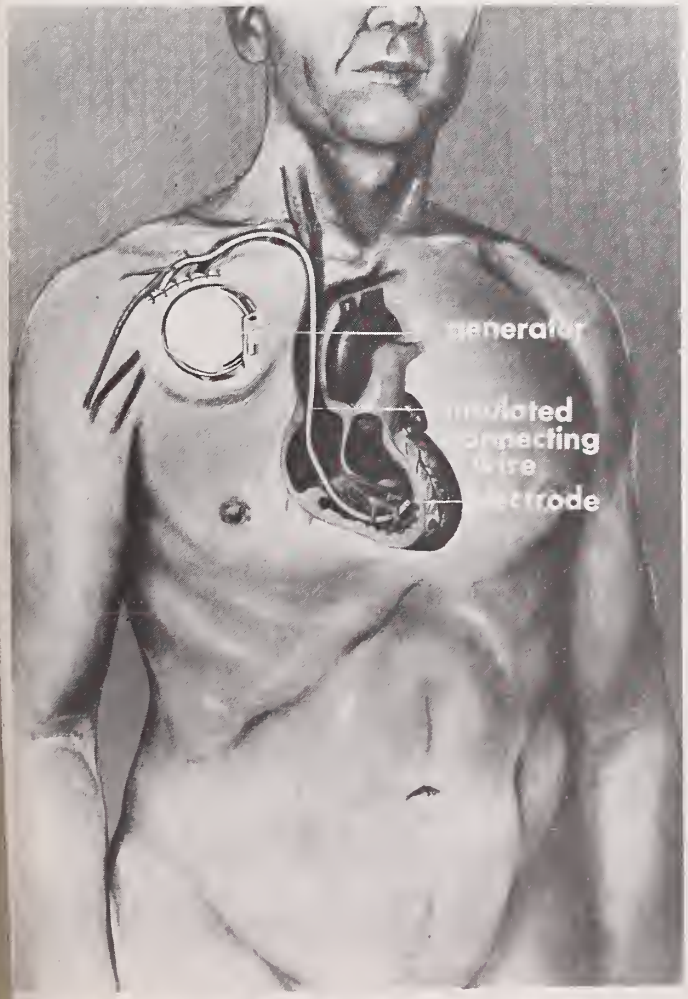


Figure 7A — Endocardial pacemaker placement and components.

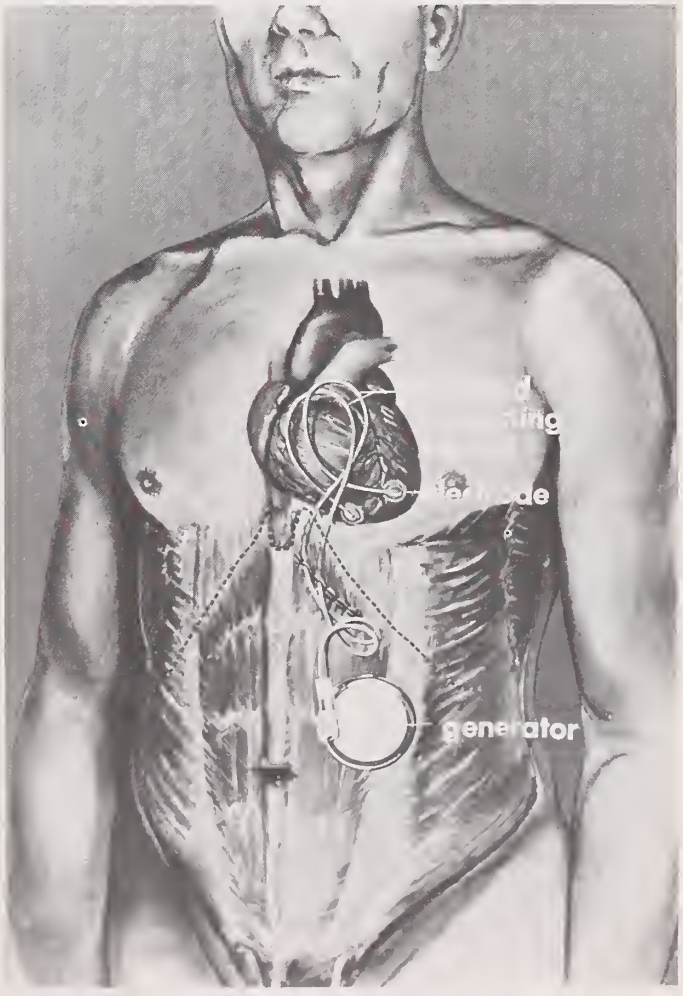


Figure 7B — Epicardial pacemaker placement and components.

tion may cause pacemaker malfunction, the majority of pacemaker problems relate to generator failure. In the newer model generators, a predictable decrease occurs in pacemaker firing rate as the generator voltage decreases; the firing rate declines progressively with serial battery cell failure. Therefore, monitoring the patient for a decrease in pacemaker firing rate enables replacement of the generator before complete pacemaker failure occurs. The standard electrocardiogram can be used to check both the sensing and the pacing function of the pacemaker. When the pacemaker functions in the demand mode, its rate of firing can be determined from the electrocardiogram; a decrease in firing rate reflects generator power loss and indicates the need for battery replacement (Figure 8). However, when the patient's intrinsic heart rate is more rapid than the pacemaker firing rate, no pacemaker activity is evident on the electrocardiogram. Placing a magnet appropriate for that particular pacemaker on the patient's skin over the generator activates a magnetic reed switch which converts the pacemaker from the ventricular inhibited to the asynchronous or fixed mode, thus permitting an electrocardiographic assessment of the firing rate. In order to assess the competency of electrode function, the physician should feel the pulse when the electrocardiogram is recorded and indicate its timing by pressing the ECG marker. A palpable pulse should follow each electrocardiographic pacemaker impulse if electrode function is intact. Additionally, a nonconducted pacemaker spike can readily be differentiated electrocardiographically from a conducted one in that only the latter will be followed by a T wave (Figure 9).

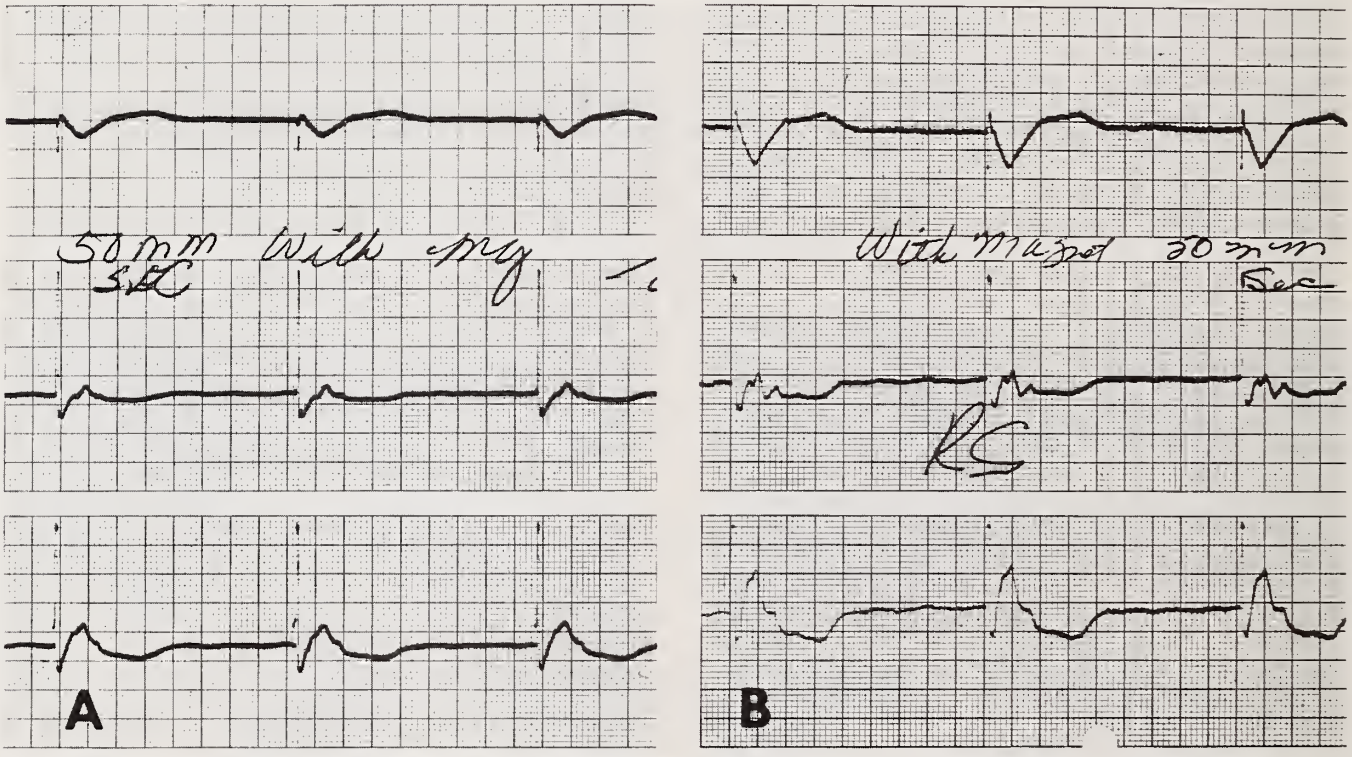


Figure 8 — Decrease in pacemaker firing rate as evidence of pacemaker failure. A. 2-2-77, 840 msec.; 2-17-77, 920 msec.

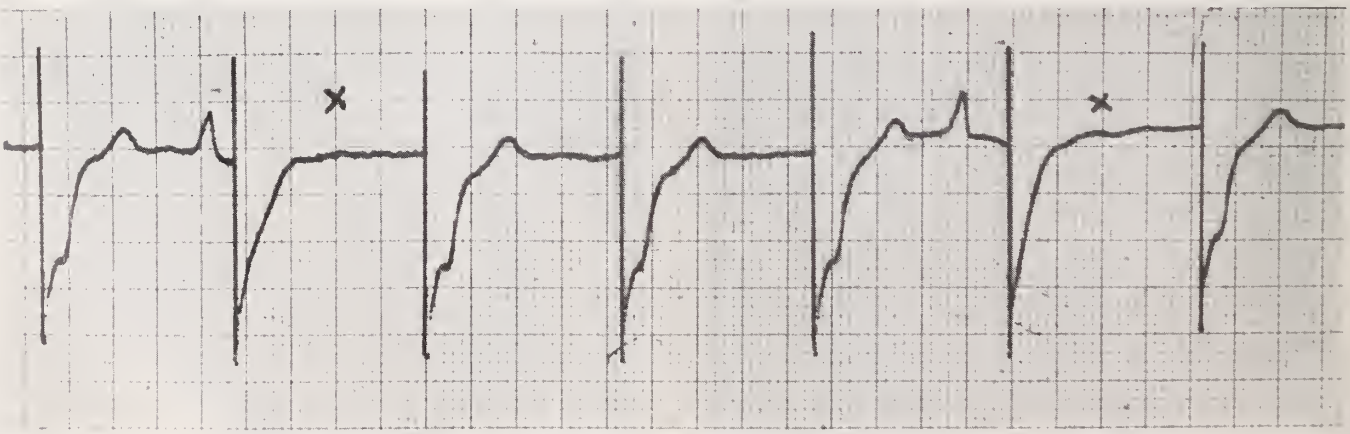


Figure 9 — Non-conducted pacemaker spike. No T wave (x) follows pacemaker spike with failure to pace; pacemaker spike falls in refractory period of ventricle (note patient's own QRS complex).

The electrocardiogram provides even more information about a cardiac pacemaker. For example, it can identify the site of pacemaker placement. A right ventricular endocardial pacemaker has the electrocardiographic pattern of left bundle branch block (Figure 10), in that the pacemaker initially activates the right ventricle, whereas a left ventricular epicardial pacemaker has the electrocardiographic pattern of right bundle branch block (Figure 11), because the epicardial pacemaker first activates the left ventricle. Pacemaker electrode problems may be identified by a change in the electrocardiographic pattern. For example, if a patient with a right ventricular endocardial pacemaker develops right bundle branch block instead of the expected left bundle branch block, several complications must be considered. The pacemaker electrode may have come loose, doubled back into the right atrium, and entered the coronary sinus, thus initially stimulating the left ventricle. The pacemaker electrode may have perforated the septum, permitting initial left ventricular stimulation. Or, the pacemaker may have perforated the free wall of the right ventricle, migrated into the pericardium, and thus initially stimulated the left ventricle. When a change in electrocardiographic pattern occurs, PA and lateral chest films are mandatory to ascertain electrode position, identify the problem, and evaluate for intervention (Figure 12).

Pacemaker patients are commonly also followed by transtelephonic monitoring. This is an effective but more costly system which can record the patient's electrocardiogram and, with the patient using the magnet to convert the generator to a fixed-rate mode, it can record pacemaker function and rate in the patient whose intrinsic heart rate may be faster than that set for pacemaker firing.

An equally efficient and far more economical method is the patient's self-monitoring of pacemaker

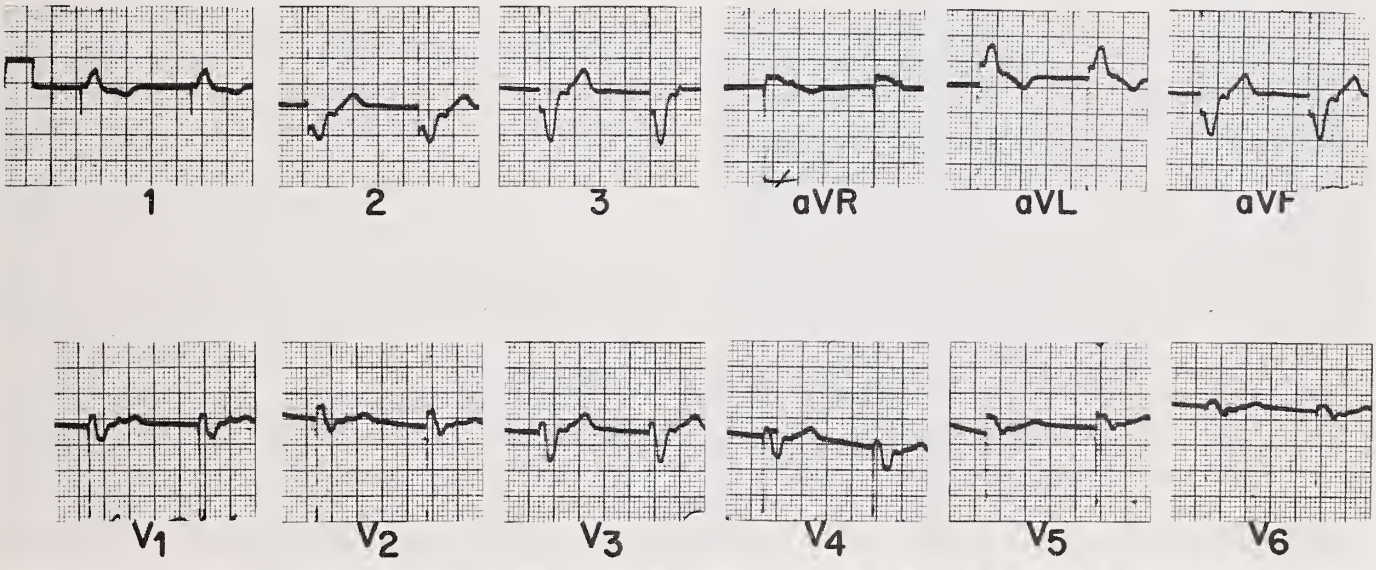


Figure 10 — Left bundle branch block pattern: endocardial pacemaker in right ventricle.

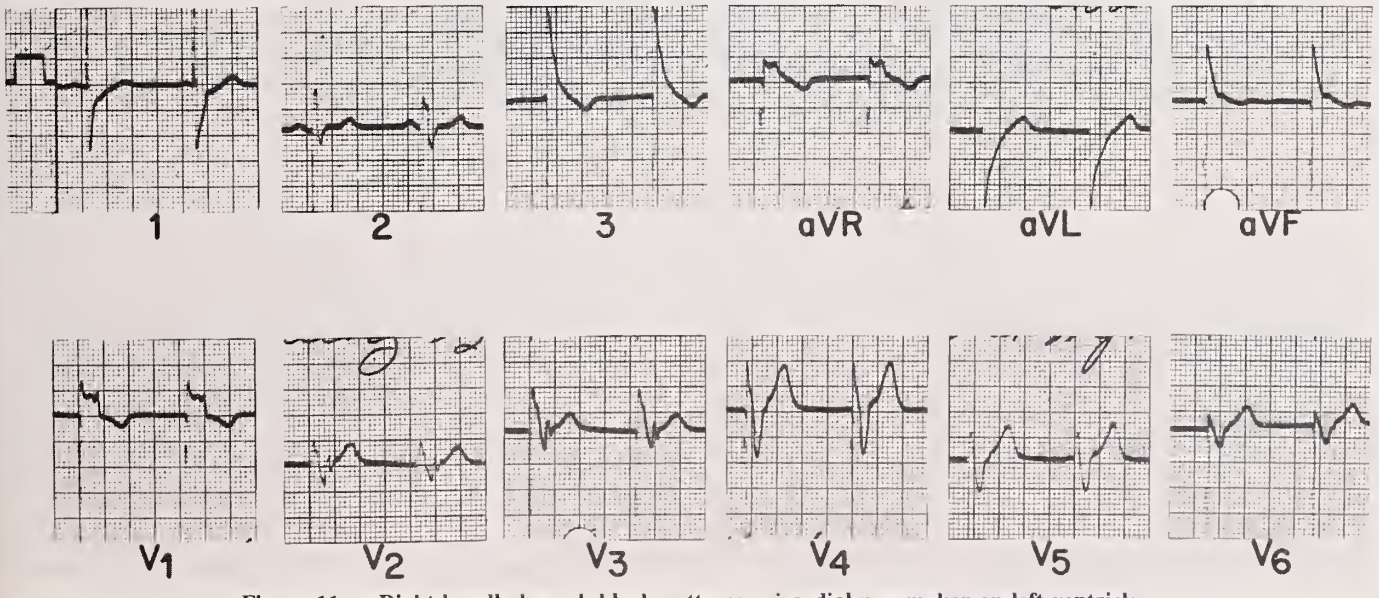


Figure 11 — Right bundle branch block pattern: epicardial pacemaker on left ventricle.

function at home. Ideally, this is done twice daily, between physician visits. Patients and/or their families can readily learn to check both the generator and the electrode components. The basis for home monitoring is the emission of a radio wave with each pacer firing, heard as a click when an inexpensive AM transistorized radio placed over the generator is set at 550 kilocycles. The patient initially places the magnet over the generator, converting it to an asynchronous or fixed-rate mode, positions the transistor radio (set at 550 kilocycles and turned up to maximal volume) over the magnet, and counts and records the clicks for a full minute. A variation of greater than four to five clicks per minute or any irregularity of the clicks is considered a possible indication of pacemaker failure and should be reported immediately to the physician. The patient next checks for electrode competency by determining the effect of the paced impulses on the pulse. The patient removes the magnet from over the generator, restoring the pacemaker to the ventricular inhibited or demand function, and places the radio over the generator to assess click-pulse relationships. Regular clicks, indicating regular pacemaker firing, should be followed by a pulse beat (that is, click, pulse, click, pulse). This indicates that the electrode connections are intact and that the pacemaker effects ventricular contraction. The patient does not count the pulse rate or the click rate, but simply identifies that a pulse beat follows each click. When an implanted demand pacemaker only functions intermittently, pacemaker clicks are heard at irregular intervals. However, even in this instance, electrode competency is identified by a pulse beat following each audible click. If no pacemaker clicks are audible, indicating that the pacemaker is not firing, it must have been inhibited by a heart rate more rapid than its firing rate. The patient is instructed to count the pulse, which should then be more rapid than the pacemaker rate because it has inhibited pacemaker firing. This indicates adequate electrode sensing function.

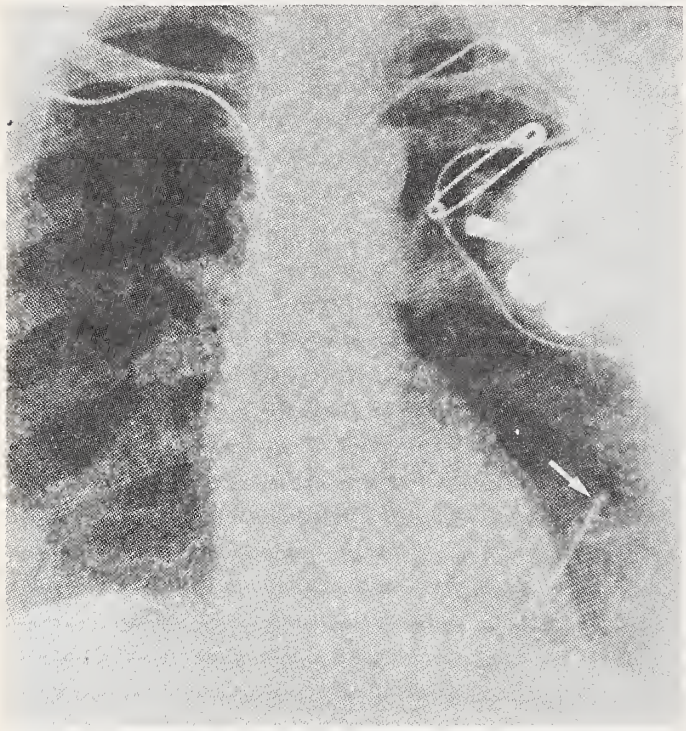


Figure 12 — X-ray of the chest demonstrating perforation of the heart by a transvenous pacemaker catheter (arrow).

It is critical to assume that patients with implanted pacemakers who describe intermittent symptoms, particularly dizziness, lightheadedness, or syncope,

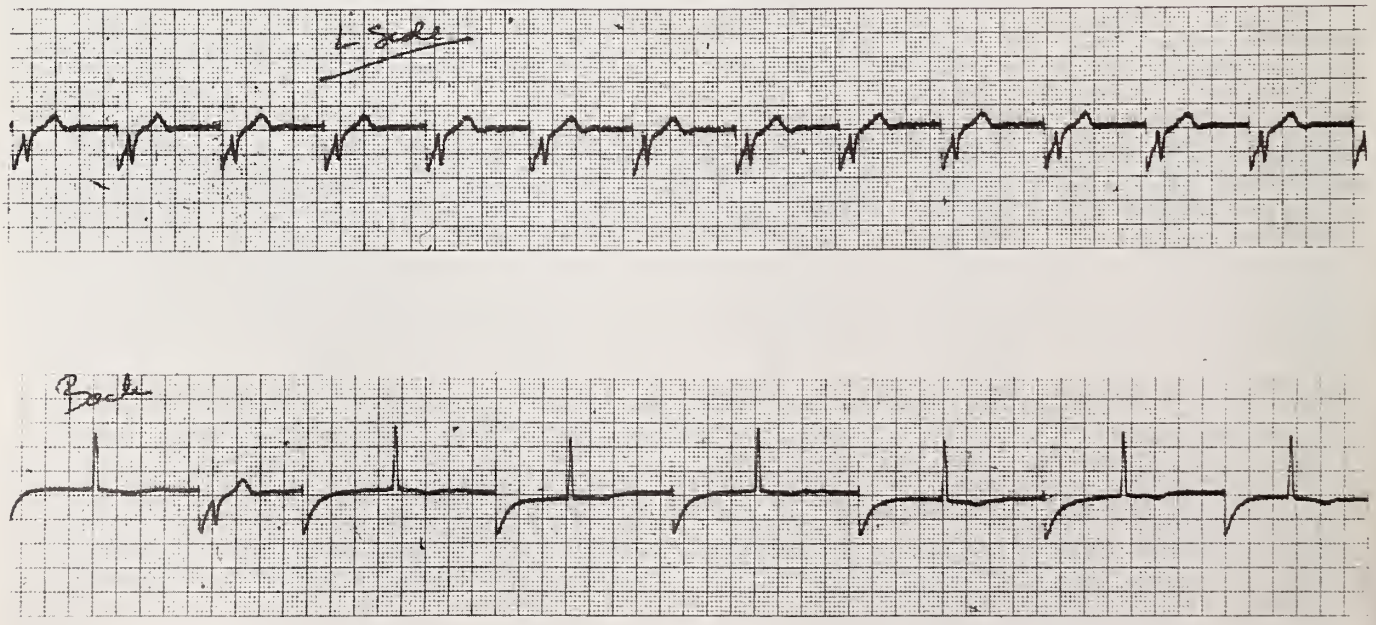


Figure 13 — Failure to pace with position change. Top: regular pacing with patient lying on left side. Bottom: only intermittent pacing with patient lying on back. Note that only first pacer impulse is conducted.

have intermittent pacemaker malfunction until proved otherwise. Even when electrocardiographic and home monitoring, as described above, show no evidence of pacemaker malfunction, it must be ascertained if the symptoms are position or activity related and an attempt should be made to reproduce that position or activity during an electrocardiographic recording (Figure 13). For example, a patient with a loose or partially broken connecting wire may demonstrate pacemaker malfunction only when raising the arm above the head; this may be confirmed by x-ray or fluoroscopy assessment of electrode breakage or malposition. Finally, long-term ambulatory electrocardiographic monitoring is extremely valuable in detecting intermittent pacemaker malfunction, with a patient diary required to correlate electrocardiographic pacemaker abnormalities with reported symptoms.

Understanding pacemaker components and common modes of malfunction enables effective and economical ambulatory surveillance of patients with implanted cardiac pacemakers. This can be achieved by a combination of home self-monitoring and electrocardiographic assessment in the physician's office at the time of routine cardiac care. Transtelephonic pacemaker monitoring may be supplementary.

Summary

The clinician caring for patients in the older age group should be familiar with three common problems seen with increased frequency in the elderly. These problems, calcific aortic stenosis, mitral annular calcification and/or myxomatous valve degeneration, and conditions requiring pacemaker implantation and subsequent surveillance, have been reviewed, with emphasis on diagnostic and therapeutic implications.

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Advances in the Pharmacologic Management of Asthma

WILLIAM J. BRANAN JR., M.D., and BETTY B. WRAY, M.D., *Augusta**

SEVERAL NEW TYPES of drugs, as well as modifications of older ones, have improved the management of patients with bronchial asthma. Bronchospasm, mucosal edema, and mucus production can be triggered by allergens, irritants, viral infections, aspirin, emotional upsets, exercise, and other stimuli in those individuals predisposed to respond in this manner.

The major improvement in the use of theophylline is related to the widespread availability of measurement of concentrations of this drug in the serum by the EMIT† method which is specific for theophylline (but does not measure dyphylline). Therapeutic levels are usually in the range of 5-20 mcg/ml, and greater concentrations are usually related to toxic symptoms. Since there is a great deal of individual variation in the degradation rate of theophylline, the serum concentration is very helpful in adjusting the dosage when there is any question of toxicity or failure of efficacy.[1] Long acting and more slowly released oral forms of the drug can now provide relatively constant serum concentrations with twice daily dosage, which is convenient for the patient needing medication regularly. A liquid preparation for rectal administration provides for more precise dosage and absorption than does the suppository form.

The major improvement in adrenergic agents is the availability of metaproterenol, which is longer acting than isoproterenol, in both aerosol and oral form, tablets and liquid.[2] Terbutaline is also available in tablet and injectable forms. An aerosol of terbutaline reportedly will soon be available with a metered dose type of device. Both of these drugs, as well as isoetharine, produce relatively more bronchial muscle relaxation ($Beta_2$ activity) than cardiac effect ($Beta_1$), especially in the aerosolized form. The predominant side effects of oral use is muscle tremor, which is usually transient. The only other adrenergic agent available is ephedrine which has considerable alpha as well as $Beta_1$ and $Beta_2$ activity.[3] The alpha component provides vasoconstriction which is helpful with mucosal edema that is especially important in young children with small airways. Any of the adrenergic agents should be administered with caution to patients with coronary artery disease, cardiac failure, or hypertension.

Cromolyn (disodium chromoglycate), which is administered by inhalation of powder from a capsule, has been found to act as a preventative which is effective for some patients with asthma. Through an unknown mechanism, the drug stabilizes mast cells, preventing or diminishing the release of mediators of the allergic reaction. It is not effective for acute attacks.[4]

Aerosolized beclomethasone is the first of the topical steroids marketed for prophylaxis of but not therapy for acute asthma. Much less is absorbed systemically than with dexamethasone, the only other steroid available as an aerosol. However, it has been documented that some adrenal suppression occurs, even with average doses of beclomethasone, on the same order as occurs with alternate day doses of short acting steroids.[5] It is wise to use the smallest dose of systemic steroids possible for the shortest period of time. Yet, when the patient is not responding to theophylline and adrenergic agents or is obtaining only transient relief, then a short course of steroids (usually a week or less) can frequently prevent the occurrence of status asthmaticus.

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† Syva Laboratories, 3181 Porter Dr., Palo Alto, CA 94304.

Although the mechanisms by which exercise elicits airway obstruction remain obscure, patients with true exercise-induced bronchospasm with overt wheezing or a 10-50% decrease in FEV_1 may benefit from any one of several medications. Adrenergic agents with $Beta_2$ activity, theophylline, or cromolyn have been used successfully. Metaproterenol by inhalation is most effective when administered a few minutes before exercise. If a more prolonged response is required for sustained activity, then an oral $Beta_2$ agent should be used 30-60 minutes prior to exercise. Inhalation of cromolyn 15 to 60 minutes before exercise affords protection to some asthmatics. With the use of these medications, many patients with asthma are able to participate in exercise programs without significant symptoms.

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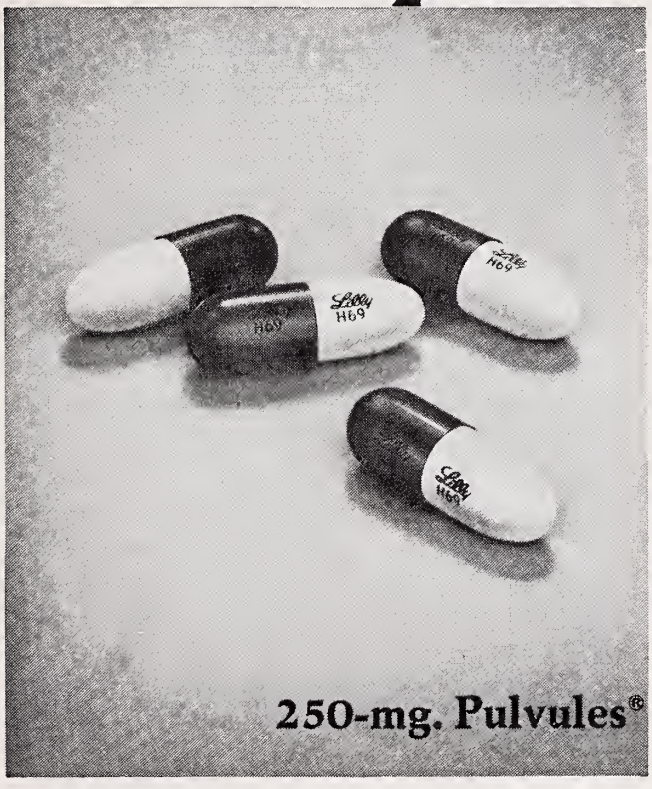
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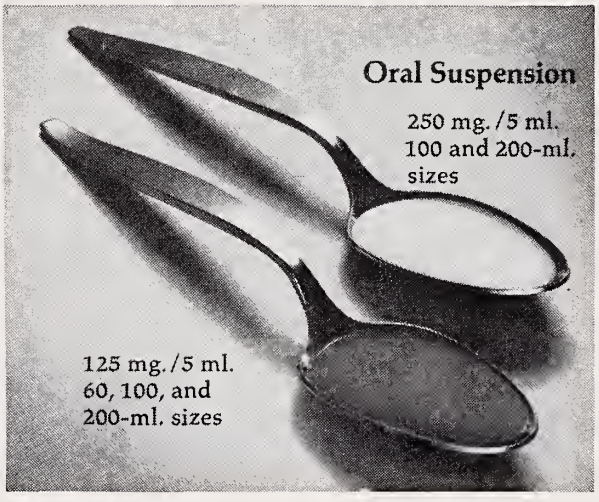
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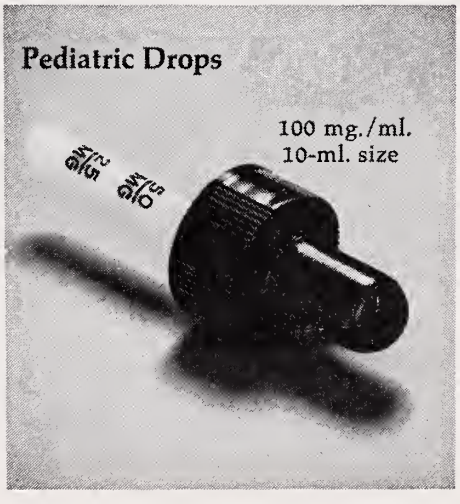
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Anesthetic Management of a Pregnant Patient With Malignant Hyperpyrexia Susceptibility

JOHN A. YOUNGBERG, M.D., *Atlanta**

SAFE AND EFFECTIVE anesthesia for a patient known to be at risk for developing malignant hyperpyrexia (MH) is a rare but challenging problem.[1] Many case reports have appeared in the literature, but few have dealt with or considered this problem in pregnancy.[2, 3] The following is a report of a 20-year-old pregnant patient with a positive muscle biopsy and a positive family history for malignant hyperpyrexia. Delivery was accomplished under a chloroprocaine epidural, and the patient subsequently underwent drainage of a vaginal wall hematoma under intravenous meperidine and local infiltration of chloroprocaine.

Case Report

A 20-year-old gravida 1 para 0 caucasian woman was admitted for delivery at 1830 hours. Family history included a younger sister who had died from a malignant hyperpyrexia episode during surgery. Because of this, a muscle biopsy had been performed earlier in this patient's pregnancy, and the result was a positive halothane stimulation response. The rest of the patient's history was unremarkable except for a pilonidal cyst that was drained under topical freezing 3 months before she was admitted for this delivery.

A physical examination on admission was normal as were the laboratory studies. She weighed 62.5 kg and was 167.6 cm tall. The patient was placed on a cooling blanket, intravenous and arterial lines were put in place, and ECG and temperature monitoring were begun. An epidural catheter was put in place, and pre-delivery analgesia was maintained with intermittent doses of 3% chloroprocaine. She received a test dose of 3 mls of 3% chloroprocaine at 2215 hours, and analgesic doses of 4 mls, 4 mls, and 5 mls at 2300, 2345, and 0030 hours, respectively.

At 0115 the next morning, the patient was taken to the delivery room and placed on a cooling blanket. A dose of 9 mls of 3% chloroprocaine was injected through the epidural catheter to achieve adequate anesthesia. Temperature, ECG, pulse rate, direct arterial pressure, blood gases, and respirations were monitored. The patient delivered a 3.6 kg male infant at 0158. She was returned to the operating room at 1130, and a vaginal wall hematoma was drained under 3% chloroprocaine local infiltration and 50 mg meperidine given intravenously. The patient became acidotic, pH 7.44 BE −10 (metabolic), during the second anesthetic and responded readily to sodium bicarbonate. This acidosis was felt not to be a manifestation of MH, since the $Paco_2$ was 20 torr, she was not tachycardic, muscle rigidity was not apparent, and the enzyme studies done at that time and later were only minimally elevated. This acidosis was felt to be secondary to a build-up of lactic acid in the tissues during the relative hypoperfusion experienced during delivery and the postpartum period. Blood was drawn for chemical analysis for CPK, LDH, SGOT, Ca^{++}, K^{+}, and alkaline phosphatase on admission, at the beginning of the second stage of labor, at the end of delivery, during the second anesthetic, the following morning, and 48 hours postpartum. The CPK and alkaline phosphatase were only mildly elevated during delivery and 48 hours postpartum. The patient experienced no signs or symptoms of MH and was discharged on the fourth postpartum day.

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Discussion

MH is an inherited autosomal dominant myopathy.[4, 5] Reports of hyperthermia have appeared in the literature since 1900, but Denborough is credited with first describing the syndrome in 1962.[6] An estimate of the disease in the population as a whole is approximately 1 in 20,000.[3] Approximately 55% of the cases occur in males, and most cases occur in younger patients, with the mean age being 22 years and the greatest incidence in the 0-10 year group. The syndrome manifests itself in both the rigid or non-rigid forms, with the rigid variety being far more common. Both varieties may exist in the same family. MH is thought to be the result of a defect in intracellular metabolism, with an uncoupling of oxidative phosphorylation and an insufficient supply and production of ATP. The muscle rigidity is thought to be secondary to a decreased uptake of calcium by the sarcoplasmic reticulum.[7]

Approximately 67% of the patients at risk have muscle anomalies. There is usually an increase in muscle bulk and strength with rounded muscle bellies. There may be joint hypermobility with a history of dislocations. These patients may complain of muscle cramps during or shortly after exercise. There may be a history of high fevers with high environmental temperatures, minor infections, muscle injury or exercise, or extreme emotional excitement.[17] Any patient should be tested who has a family history of MH, gives a history of a family member having a high temperature or dying under anesthesia, or in whom you strongly suspect the syndrome. The patient suspected to be at risk should be treated as such, regardless of testing results.

Malignant hyperpyrexia is thought to be the result of a defect in intracellular metabolism.

There are many tests reported to determine those patients who are at risk for MH. Although none of the tests are 100% accurate and give both false-positive and false-negative results, some tests are extremely accurate. The easiest one to perform is to measure serum CPK; however, many susceptible patients may have normal values.[8] Kalow and Britt have reported a caffeine stimulation test on quadriceps muscle and demonstrate four genetic groups by this test.[9] Ellis and Keaney described a halothane stimulation test in which only abnormal muscles responded.[10] Electromyographic studies have also been described.[11] Even though the patient reported on here had three normal serum CPK's during her pregnancy, a halothane stimulation test was performed on a muscle biopsy, with positive results. Electron microscopy studies were not conclusive. In view of the positive halothane stimulation test, it was concluded that our patient was at risk.

MH episodes following the use of anectine, halothane, anticholinergics, amide-type local anesthetics, curare, etc. have been reported.[1, 12, 13, 14] For that reason, the patient was not pre-medicated, and an ester type of local anesthetic was used for an epidural. The possibility of pretreatment of the patient with dantrolene sodium as described by Harrison was considered but discarded since dantrolene sodium has been shown to have muscle relaxation properties, and its effect on the newborn is unknown.[15] Oral dantrolene prophylaxis is recommended, however, in nonpregnant patients at risk.

Patients should be questioned closely as to family history of difficulty under anesthesia, and muscle biopsies should be performed on patients suspected of being at risk.

Pretreatment with a combination of reserpine and alpha blockers has also been described as affording protection.[16] No sedation was used during labor and delivery because this patient had been well prepared in the months prior to delivery and had essentially no discomfort or anxiety with the epidural anesthetic.

Not all patients who have MH experience muscle rigidity but most experience hypercarbia, acidosis, myoglobinuria, hyperkalemia, dysrrhythmia, hypercalcemia, and hyperpyrexia.[17, 18] Therefore, these patients should have ECG, temperature, and blood pressure monitoring in addition to being placed on a cooling blanket. We recommend an indwelling arterial cannula for blood gas determinations. Ice, iced solutions, sodium bicarbonate, and procainamide should be available for treatment.[19] Dantrolene sodium is also recommended.[15, 17]

Summary

We have described a pregnant patient with a positive family history of malignant hyperpyrexia who had three successive normal serum CPK's but had a positive halothane stimulation test on a muscle biopsy. She underwent epidural anesthesia for delivery and combination local infiltration and intravenous meperidine anesthesia for drainage of a vaginal wall hematoma.

It is recommended that patients be questioned closely as to family history of difficulty under anesthesia and that muscle biopsies be performed in the evaluation of patients suspected of being at risk for MH.

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ERRATUM: In the article, "Acoustic Neuroma — Current Diagnosis and Treatment," in the October 1979 *Journal,* Figure 5 on p. 909 of the two CT scans is positioned incorrectly. It is upside down as shown. We sincerely apologize for this error.

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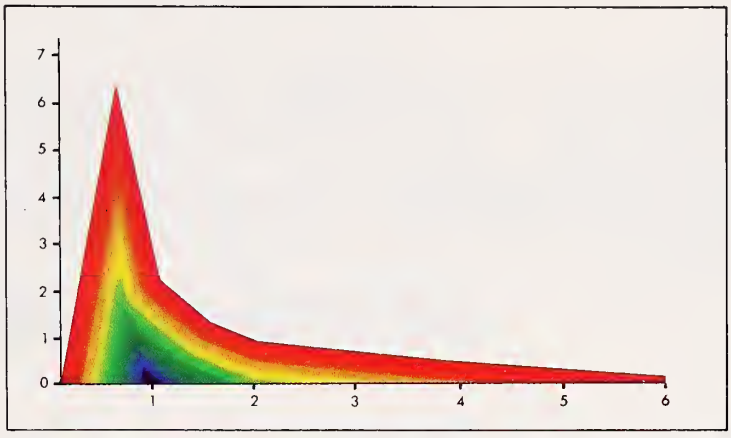
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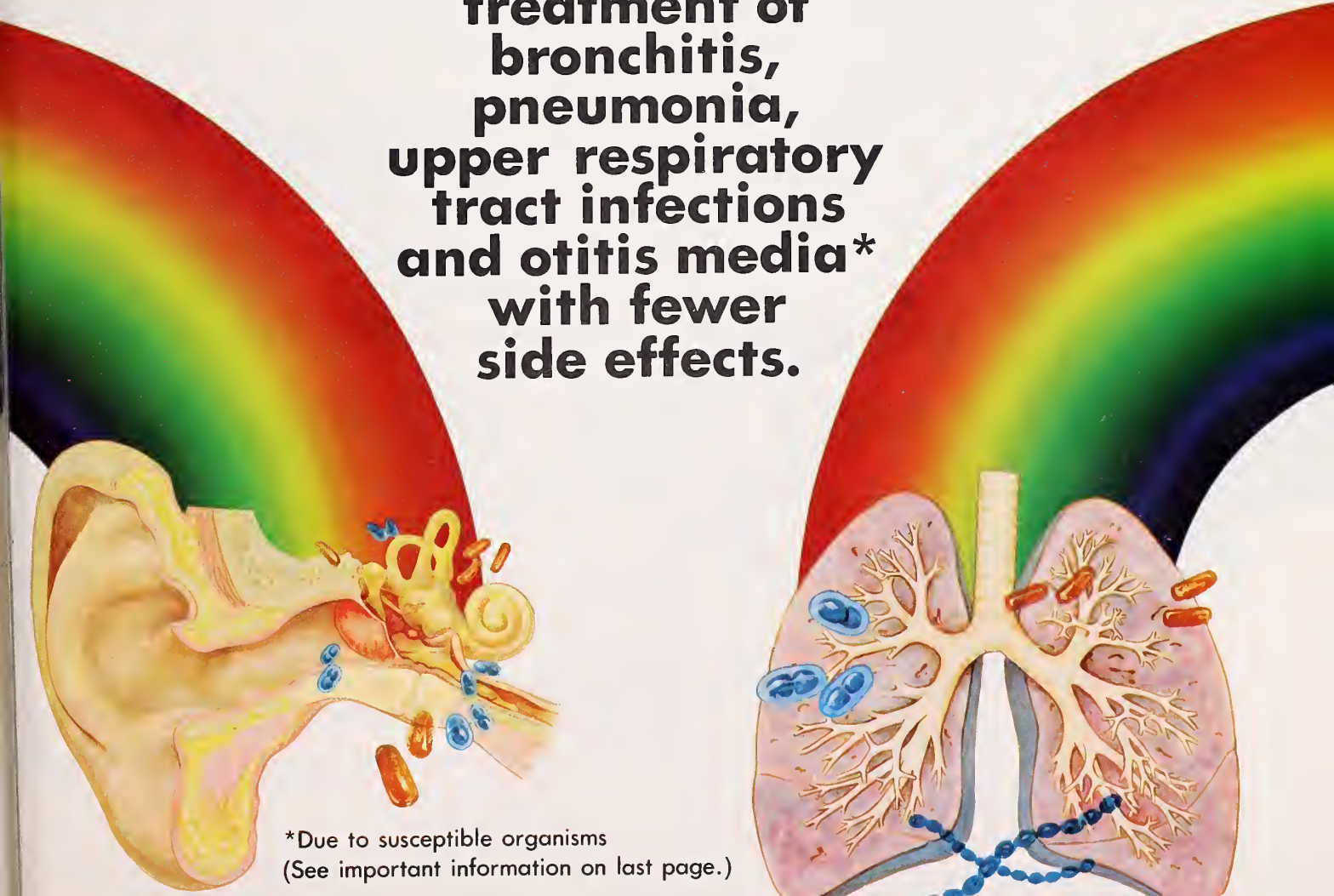
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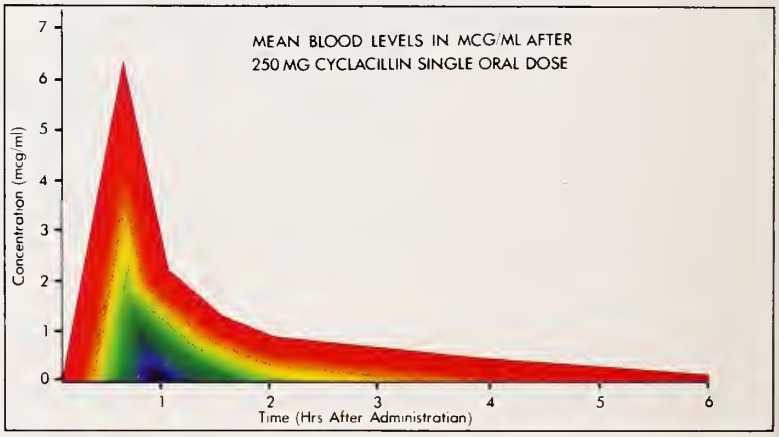
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Rapidly excreted unchanged in the urine—1½ times faster than ampicillin



High cure rate with CYCLAPEN®		
Causative Organism	Bronchitis/Pneumonia†	No. of Patients
S. pneumoniae	100 / 95	73
Chronic Bronchitis† (acute exacerbation)		
H. influenzae	92	12
	Though clinical improvement has been shown, bacteriologic cures cannot be expected in all patients with chronic respiratory disease due to *H. influenzae*	
Streptococcal Sore Throat†		
Group A beta-hemolytic Streptococcus	100 / 86	44
% Clinical Response % Bacterial Eradication		



more than just spectrum in bronchitis, pneumonia and upper respiratory tract infections†

*Includes all patients treated. 2,415 evaluated for safety; 1,819 evaluated for efficacy.

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effects than double-blind patients*

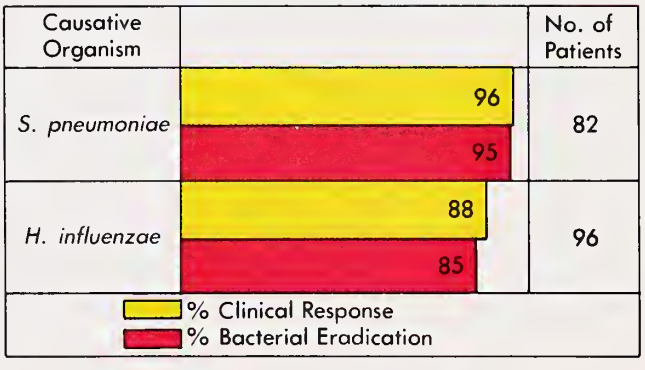


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CYCLAPEN® (cyclacillin)
Effective for bronchitis, pneumonia, and upper respiratory tract infections†

- Excellent clinical results in bronchitis, pneumonia and upper respiratory tract infections
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1. Gold JA, Hegarty CP, Deitch MW, Walker BR: Double-blind clinical trials of oral cyclacillin and ampicillin, *Antimicrob Ag Chemother* 15:55-58, (Jan.) 1979.
2. Data on file, Wyeth Laboratories.

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100 ml and 200 ml bottles

Indications

Cyclapen® (cyclacillin) has less in vitro activity than other drugs in the ampicillin class of antibiotics and its use should be confined to the indications listed below.

Cyclapen® is indicated for the treatment of the following infections:

RESPIRATORY TRACT
Tonsillitis and pharyngitis caused by Group A beta-hemolytic streptococci
Bronchitis and pneumonia caused by *S. pneumoniae* (formerly *D. pneumoniae*)
Otitis Media caused by *S. pneumoniae* (formerly *D. pneumoniae*) and *H. influenzae*
Acute exacerbation of chronic bronchitis caused by *H. influenzae**
*Though clinical improvement has been shown, bacteriologic cures cannot be expected in all patients with chronic respiratory disease due to *H. influenzae*.

SKIN AND SKIN STRUCTURES (integumentary) infections caused by Group A beta-hemolytic streptococci and staphylococci, non-penicillinase producers.

URINARY TRACT INFECTIONS caused by *E. coli* and *P. mirabilis*. (This drug should not be used in any infections caused by *E. coli* and *P. mirabilis* other than urinary tract infections.)

NOTE: Cultures and susceptibility tests should be performed initially and during treatment to monitor the effectiveness of therapy and the susceptibility of bacteria. Therapy may be instituted prior to the results of sensitivity testing.

Contraindications

The use of this drug is contraindicated in individuals with a history of an allergic reaction to penicillins.

Warnings

CYCLACILLIN SHOULD ONLY BE PRESCRIBED FOR THE INDICATIONS LISTED IN THIS INSERT.

CYCLACILLIN HAS LESS *IN VITRO* ACTIVITY THAN OTHER DRUGS OF THE AMPICILLIN CLASS ANTIBIOTICS. HOWEVER, CLINICAL TRIALS HAVE DEMONSTRATED THAT IT IS EFFICACIOUS FOR THE RECOMMENDED INDICATIONS.

SERIOUS AND OCCASIONAL FATAL HYPERSENSITIVITY (ANAPHYLACTOID) REACTIONS HAVE BEEN REPORTED IN PATIENTS RECEIVING PENICILLIN.

ALTHOUGH ANAPHYLAXIS IS MORE FREQUENT FOLLOWING PARENTERAL ADMINISTRATION, IT HAS OCCURRED IN PATIENTS ON ORAL PENICILLINS. THESE REACTIONS ARE MORE APT TO OCCUR IN INDIVIDUALS WITH A HISTORY OF SENSITIVITY TO MULTIPLE ALLERGENS. THERE ARE REPORTS OF PATIENTS WITH A HISTORY OF PENICILLIN HYPERSENSITIVITY REACTIONS WHO EXPERIENCED SEVERE HYPERSENSITIVITY REACTIONS WHEN TREATED WITH A CEPHALOSPORIN. BEFORE THERAPY WITH A PENICILLIN, CAREFUL INQUIRY SHOULD BE MADE ABOUT PREVIOUS HYPERSENSITIVITY REACTIONS TO PENICILLINS, CEPHALOSPORINS, AND OTHER ALLERGENS. IF AN ALLERGIC REACTION OCCURS, THE DRUG SHOULD BE DISCONTINUED AND APPROPRIATE THERAPY SHOULD BE INITIATED. SERIOUS ANAPHYLACTOID REACTIONS REQUIRE IMMEDIATE EMERGENCY TREATMENT WITH EPINEPHRINE. OXYGEN, INTRAVENOUS STEROIDS, AIRWAY MANAGEMENT, INCLUDING INTUBATION, SHOULD ALSO BE ADMINISTERED AS INDICATED.

Precautions

Prolonged use of antibiotics may promote the overgrowth of nonsusceptible organisms. If superinfection occurs during therapy, appropriate measures should be taken.

PREGNANCY: Pregnancy Category B. Reproduction studies have been performed in mice and rats at doses up to ten times the human dose and have revealed no evidence of impaired fertility or harm to the fetus due to cyclacillin. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

NURSING MOTHERS: It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk, caution should be exercised when cyclacillin is administered to a nursing woman.

Adverse Reactions

The oral administration of cyclacillin is generally well tolerated.

As with other penicillins, untoward reactions of the sensitivity phenomena are likely to occur, particularly in individuals who have previously demonstrated hypersensitivity to penicillins or in those with a history of allergy, asthma, hay fever, or urticaria.

The following adverse reactions have been reported with the use of cyclacillin: diarrhea (in approximately 1 out of 20 patients treated), nausea and vomiting (in approximately 1 in 50), and skin rash (in approximately 1 in 60). Isolated instances of headache, dizziness, abdominal pain, vaginitis, and urticaria have been reported. (See WARNINGS)

Other less frequent adverse reactions which may occur and that have been reported during therapy with other penicillins are: anemia, thrombocytopenia, thrombocytopenic purpura, leukopenia, neutropenia and eosinophilia. These reactions are usually reversible on discontinuation of therapy.

As with other semisynthetic penicillins, SGOT elevations have been reported.

Dosage and Administration

INFECTION*	ADULTS	CHILDREN
		Dosage should not result in a dose higher than that for adults.
Respiratory Tract		
Tonsillitis & Pharyngitis**	250 mg q.i.d. in equally spaced doses	body weight <20 kg (44 lbs) 125 mg q.i.d. in equally spaced doses body weight >20 kg (44 lbs) 250 mg q.i.d. in equally spaced doses
Bronchitis and Pneumonia		
Mild or Moderate Infections	250 mg q.i.d. in equally spaced doses	50 mg/kg/day q.i.d. in equally spaced doses
Chronic Infections	500 mg q.i.d. in equally spaced doses	100 mg/kg/day q.i.d. in equally spaced doses
Otitis Media	250 mg to 500 mg q.i.d. in equally spaced doses depending on severity	50 to 100 mg/kg/day in equally spaced doses depending on severity
Skin & Skin Structures	250 mg to 500 mg q.i.d in equally spaced doses depending on severity	50 to 100 mg/kg/day in equally spaced doses depending on severity
Urinary Tract	500 mg q.i.d. in equally spaced doses	100 mg/kg/day in equally spaced doses.

*As with antibiotic therapy generally, treatment should be continued for a minimum of 48 to 72 hours after the patient becomes asymptomatic or until evidence of bacterial eradication has been obtained.

**In infections caused by Group A beta-hemolytic streptococci, a minimum of 10 days of treatment is recommended to guard against the risk of rheumatic fever or glomerulonephritis.

In the treatment of chronic urinary tract infection, frequent bacteriologic and clinical appraisal is necessary during therapy and may be required for several months afterwards.

Persistent infection may require treatment for several weeks.

Cyclacillin is not indicated in children under 2 months of age.

Patients with Renal Failure

Based on a dosage of 500 mg q.i.d., the following adjustment in dosage interval is recommended:

Patients with a creatinine clearance of >50 ml/min need no dosage interval adjustment.

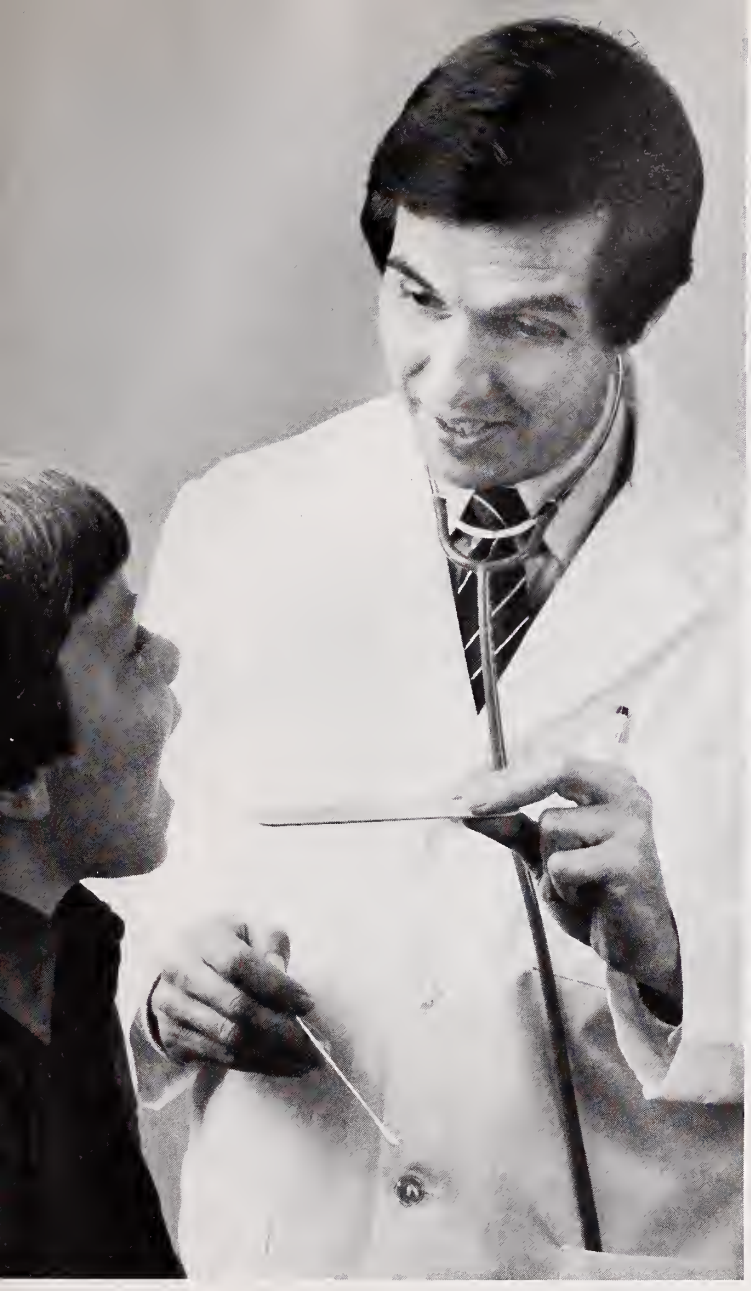
Patients with a creatinine clearance of 30-50 ml/min should receive full doses every 12 hours.

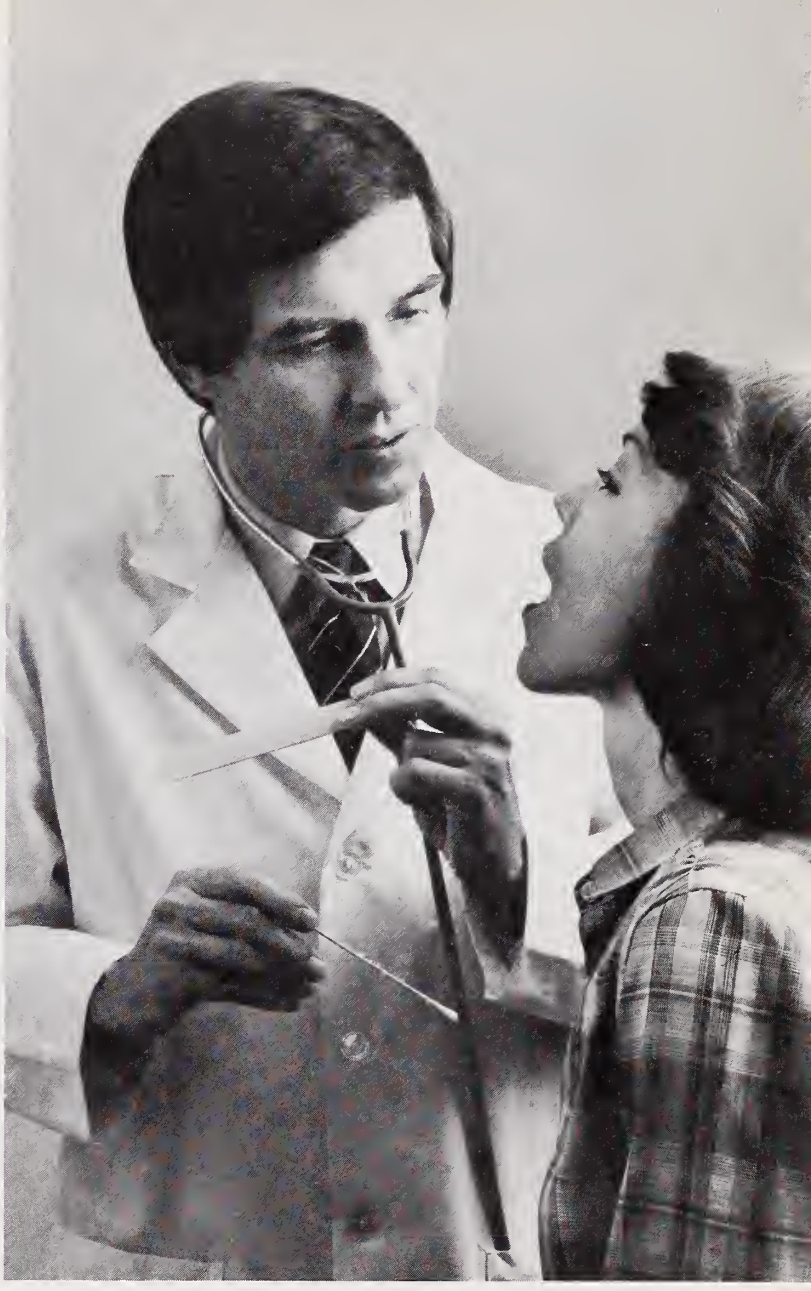
Patients with a creatinine clearance of between 15-30 ml/min should receive full doses every 18 hours.

Patients with a creatinine clearance of between 10-15 ml/min should receive full doses every 24 hours.

In patients with a creatinine clearance of <10 ml/min or serum creatinine values of ≥ 10 mg%, serum cyclacillin levels are recommended to determine both subsequent dosage and frequency.

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A case report where massive superior vena caval thrombosis caused fatal pulmonary emboli.

Superior Vena Cava and Pulmonary Artery Obstruction from Subclavian Catheters — A Case Report

S. D. ANAGOL, M.D., and S. K. MOHANTY, M.D., *Dublin**

Introduction

THROMBOEMBOLIC complications following the placement of indwelling catheters in superior or inferior vena cava have been reported. Several factors including duration, intercurrent sepsis, coiling of the catheter, and the nature of solutions infused have contributed to these complications. There have been reports of fatal pulmonary emboli[1] from inferior vena caval catheters. Superior vena caval obstructions secondary to coiling of the catheter in the left subclavian vein have been reported.[2] The following report is of a case where massive superior vena caval thrombosis caused fatal pulmonary emboli after placing superior vena caval catheters through both the subclavian veins. The emboli were found to have occluded more than 75% of the pulmonary artery lumen.

Report of a Case

A 59-year-old man presented with a history of abdominal distention and colicky peri-umbilical pain of approximately 2 months' duration. No past history of gastrointestinal symptoms was presented. His history did include a left nephroureterectomy for transitional cell carcinoma Grade II of the left renal pelvis 5 years prior to this admission. The rest of the history and systems review were unremarkable.

Physical examination revealed 2+ abdominal distention and 1+ diffuse tenderness without rigidity or rebound. Bowel sounds were hyperactive. The rest of the physical examination was unremarkable. Abdominal X-ray revealed a small bowel obstruction, dynamic type. Blood studies showed Hgb of 15.4 gram, and HCT of 45%. The total white count was 16,200 10^3, and the differential had 74% neutrophils, 6% bands, 15% lymphocytes, and 5% monocytes. The rest of the laboratory data were unremarkable. Hydration was maintained through a central venous catheter in the right subclavian vein.

The following day an exploratory laparotomy showed a mass in the upper sigmoid also involving the distal ileum and causing obstruction of the small bowel. An en masse resection of the sigmoid and the attached small bowel was done. The continuity of small bowel was restored by end-to-end anastomosis. The proximal resected end of the sigmoid was brought out as an end-colostomy, and the rectal distal segment was closed as in Hartmann's procedure. Gross and microscopic pathology of this specimen was that of sigmoid diverticulitis causing adhesion and obstruction of the small bowel. The postoperative course was complicated by fever, wound infection, and pneumonitis. On the seventh post-operative day a left subclavian catheter was introduced, and total parenteral nutrition was started through this catheter.

On the 11th postoperative day, a small bowel fistula through the wound was diagnosed. On the same day, the patient had a cardiac arrest with successful resuscitation. Following the resuscitation, a tracheostomy was done, and respiratory assistance was provided by BIRD respirator. The PO_2 with an FIO_2 of 0.6 was 68 Torr. In spite of this support, the

* Direct reprint requests to: Dr. Mohanty, Chief of Surgery, VA Medical Center, Dublin, GA 31021.

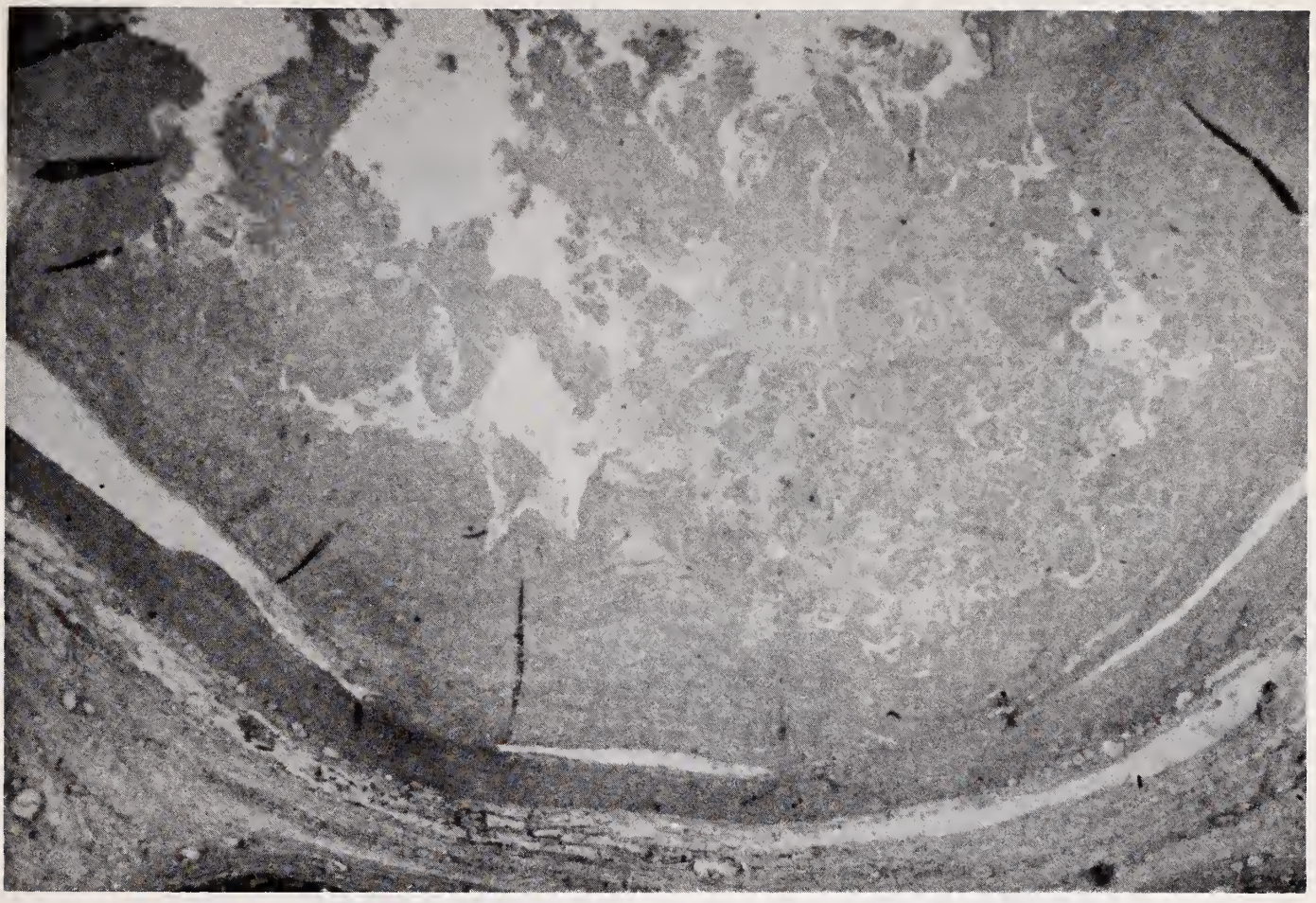


Figure 1 — Histologic section through main pulmonary artery showing thrombus obstruction.

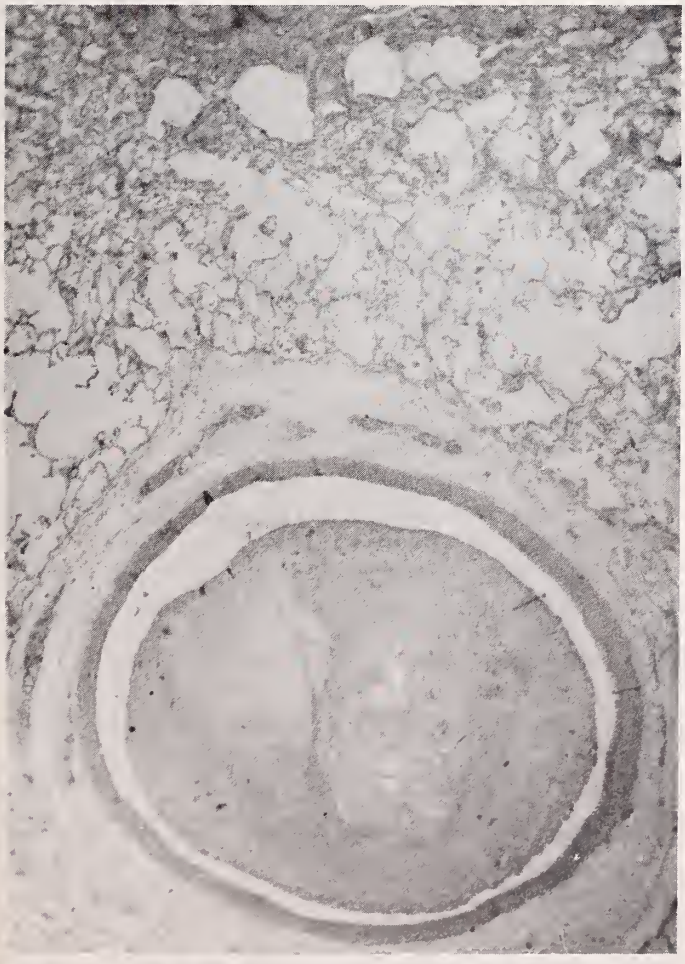


Figure 2 — Right pulmonary artery showing obstruction and adjacent lung infarction.

patient died, after a gradual deterioration, on 16th post-operative day.

At autopsy, both the indwelling catheters in the superior vena cava had organizing thrombus material attached, causing approximately 75% occlusion of the superior vena cava. The pulmonary thromboemboli arising from the indwelling venous catheter had filled the entire right atrial appendage and had extended to the main pulmonary arterial trunk, occluding 75% of the main pulmonary artery cross section. There were multiple infarctions in both lungs, and death was attributed to massive pulmonary artery obstruction.

Comments

The combined complication of massive superior vena caval thrombosis and pulmonary emboli obstructing 75% of the pulmonary artery (Figures 1 and 2) was lethal. Whether two simultaneous catheters should be placed in superior vena cava and whether this contributed to complications is speculative. To our knowledge, this combination of complications from indwelling catheters has not been reported previously.

References

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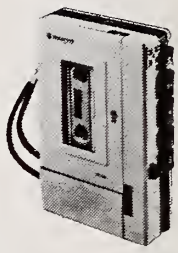
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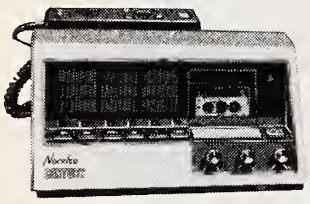


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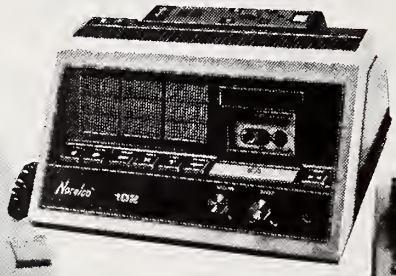
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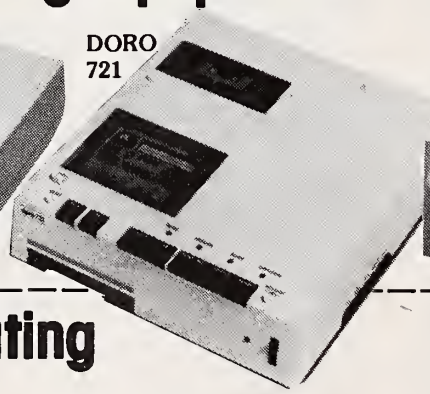


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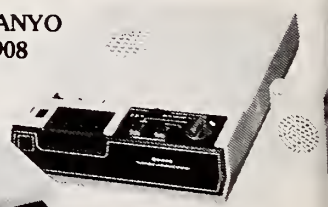
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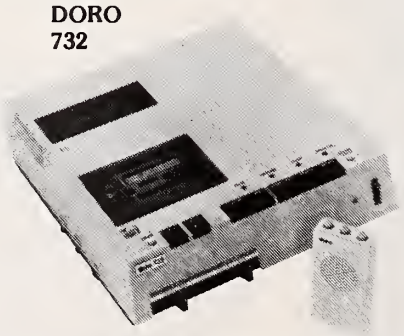


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An informative and relevant discussion of an important step in the regulation of medical care.

Certificate of Need — How It Is Affecting the Practice of Medicine in Georgia

THOMAS J. ANDERSON, M.D., and BERT FRANCO, M.A., *Atlanta**

Introduction

On October 5, 1979, Georgia reached a milestone in the regulation of medical care when the Georgia State Health Planning and Development Agency (SHPDA — pronounced "ship-da") issued Final Rules for Georgia's Certificate of Need (CoN) Act. The Rules became effective immediately and are the basis for which all CoN decisions in the state have been made since October. They already have affected the use of millions of dollars of equipment and facilities used to provide medical care. In essence, a CoN is a statement issued by a governmental agency, SHPDA, that a hospital or other health care facility meets certain requirements to enable it to spend monies to expand its facilities and/or buy new equipment. In addition, the CoN law requires that the need for all proposed new institutional health services offered in the state be determined by SHPDA.

Background

The concept of CoN was first embodied in the Comprehensive Health Planning Act of 1966 of Public Law 89-749. When this law was enacted, it placed the responsibility on the governor of each state to name a director of comprehensive health planning and to appoint a council of at least 50% "consumers" to advise the director. The director and the council were strictly advisory and had no legal means to enforce their decisions or recommendations for specific projects. On several occasions, efforts were made to enact a bill in the Georgia legislature which would require a CoN for any hospital building, modification, or addition, and on each occasion the state legislature defeated efforts to pass it.

It is imperative that physicians become acquainted with CoN legislation.

In 1974, the United States Congress passed the National Health Planning and Resources Development Act which had ramifications far beyond that which was recognized by the medical profession at the time. This law led to the development of local Health Systems Agencies (HSAs) and SHPDA. In contrast to the previous law, both the HSAs and SHPDA received power through a mandated state CoN law. SHPDA became the agency responsible for developing the CoN law and health planning in Georgia. During its 1979 session, the Georgia General Assembly passed a CoN law meeting most of the federal requirements. The law also mandated the creation of the State Health Planning and Development Commission composed of (1) the Commissioner of the Department of Human Resources, (2) the Commissioner of the Department of Medical Assistance, (3) The Comptroller General, (4) the Vice Chancellor of Health Affairs of the Board of Regents of the University System of Georgia, and (5) the Commissioner of the Department of Community Affairs. This commission now oversees SHPDA and serves as its policy-making body on major issues.

* Dr. Anderson is Chairman of MAG's Health Planning Committee. His address is 490 Peachtree St., NE, Ste. 472-C, Atlanta, GA 30308. Mr. Franco is MAG's Assistant Director of Medical Practice, 938 Peachtree St., NE, Atlanta, GA 30309.

Rules for CoN

From July 1, 1979, (the effective date of enactment of the CoN law) to October 5, 1979, SHPDA based its CoN decisions on the authority of Emergency Rules for CoN. These Rules underwent modification in a public review and comment process and eventually became the current so-called Final Rules. However, even these Final Rules are temporary and will undergo several revisions during the coming months. This is because the CoN Subcommittee of the Georgia House of Representatives Health and Ecology Committee voted in October of 1979 to reject certain provisions of the Rules and retain the authority to completely review the regulations prior to the consideration of state CoN legislation in the upcoming session of the General Assembly. The Georgia General Assembly will be considering amendments to the state CoN statute to conform to changes in state and federal law. Consequently, the Final Rules now in use will be modified significantly.

SHPDA has become the agency responsible for developing the CoN law and health planning in Georgia.

Georgia's CoN law and the Final Rules require that a variety of services and activities offered by health care facilities be certified as being necessary for the provision of medical care in Georgia. Health care facilities, as defined in the law, are hospitals, podiatric facilities, skilled nursing facilities, kidney disease treatment centers, home health agencies, health maintenance organizations, ambulatory surgical or obstetrical facilities, and intermediate care facilities. One of the most important activities covered by the Rules is the offering of new institutional health services. These are described as the construction, development, or other establishment of a new health care facility; any capital expenditure exceeding $150,000 by a facility; a change in bed capacity in a facility which increases the total number of beds, relocates beds from one facility to another, or which redistributes beds among various categories (i.e., obstetrical to surgical); computerized tomographic (CT) scanners located in covered facilities, and scanners located outside covered facilities (i.e., in physicians' offices) *if the scanners will be used for hospital in-patients;* and the purchase or lease of diagnostic or therapeutic equipment valued at more than $150,000.

Notably excluded from coverage are infirmaries operated by and for the sole use of educational institutions and private businesses; institutions operated by the federal government; offices of private physicians and dentists; Christian Science sanatoriums; the acquisition of existing facilities; and expenditures necessary to bring a facility into compliance with state and/or federal law and/or regulations.

Sanctions of the CoN Law

Sanctions vary considerably for facilities offering a new institutional health service without first obtaining a CoN. A facility which has never been licensed will be denied a license to operate. Previously licensed facilities are subject to a civil penalty of $1,000 or less. Persons failing to pay the penalty within a time period specified by SHPDA are subject to civil action by SHPDA to recover the penalty.

Many of the projects reviewed by SHPDA and the HSAs under the CoN statute are also reviewed under the authority of Section 1122 of the Social Security Act. These are for primarily capital expenditures exceeding $100,000 by hospitals and nursing homes. Section 1122 also covers the purchase of existing facilities. The sanction imposed under Section 1122 for undertaking one of these projects without SHPDA approval is the denial of Medicare and Medicaid reimbursement for the depreciation and interest on the cost of the project reviewed. Since Section 1122 penalty is more severe than the penalty under the CoN law for most projects, it is unlikely that SHPDA will terminate Section 1122 reviews until stronger sanctions are written into the state CoN statute.

Standards Used to Review CoN Projects

An important and highly controversial portion of the Final Rules is the standards used in reviewing CoN projects. SHPDA has adopted and promulgated these standards through the regulatory process rather than in conjunction with the state's HSAs, making these regulatory standards the subject of considerable and controversial discussion. These standards include numerical criteria requiring that the need for skilled nursing facilities and intermediate care facilities be based on a ratio of 55 beds per 100,000 population of people over 65 years of age residing within a residence of 40 miles of the facility. In addition, any new cardiac catheterization laboratory cannot be built if it is within 3 hours driving time to a catheterization laboratory not performing a minimum of 500 cardiac catheterizations per year. The Rules also dictate that a CoN will not be considered for a CT scanner unless all existing units in the area perform more than 2,500 procedures a year. Additional requirements are that new hospitals in rural areas should have at least a 75-bed capacity, that hospitals in a service area of 50,000 or more

population have at least a 100-bed capacity, and that projects for hospital bed additions should result in a facility of at least 50 beds.

The Look of CoN to Come

It is imperative that physicians become acquainted with state and federal CoN legislation. The rules and regulations promulgated by SHPDA will soon involve your practice and the care of your patients, if they have not already done so. Many physicians are concerned that the CoN law will be extended to cover the private offices. The Medical Association of Georgia (MAG) is working to prevent this occurrence. Pursuant to actions of its 1979 House of Delegates, the MAG is working for repeal of the CoN legislation.

It is not known to what extent the Final Rules and the state statute will be amended during the next several months. Some of the more objectionable portions of the Rules may be deleted, although this will depend on a variety of factors, such as the actions of General Assembly on the state statute and the Final Rules, the Department of Health, Education, and Welfare's enforcement of the National Health Planning and Resources Development Act, and the willingness of SHPDA to consider comments from both the public and the state's HSAs. In any event, it is certain that some modifications will be made in the Rules.

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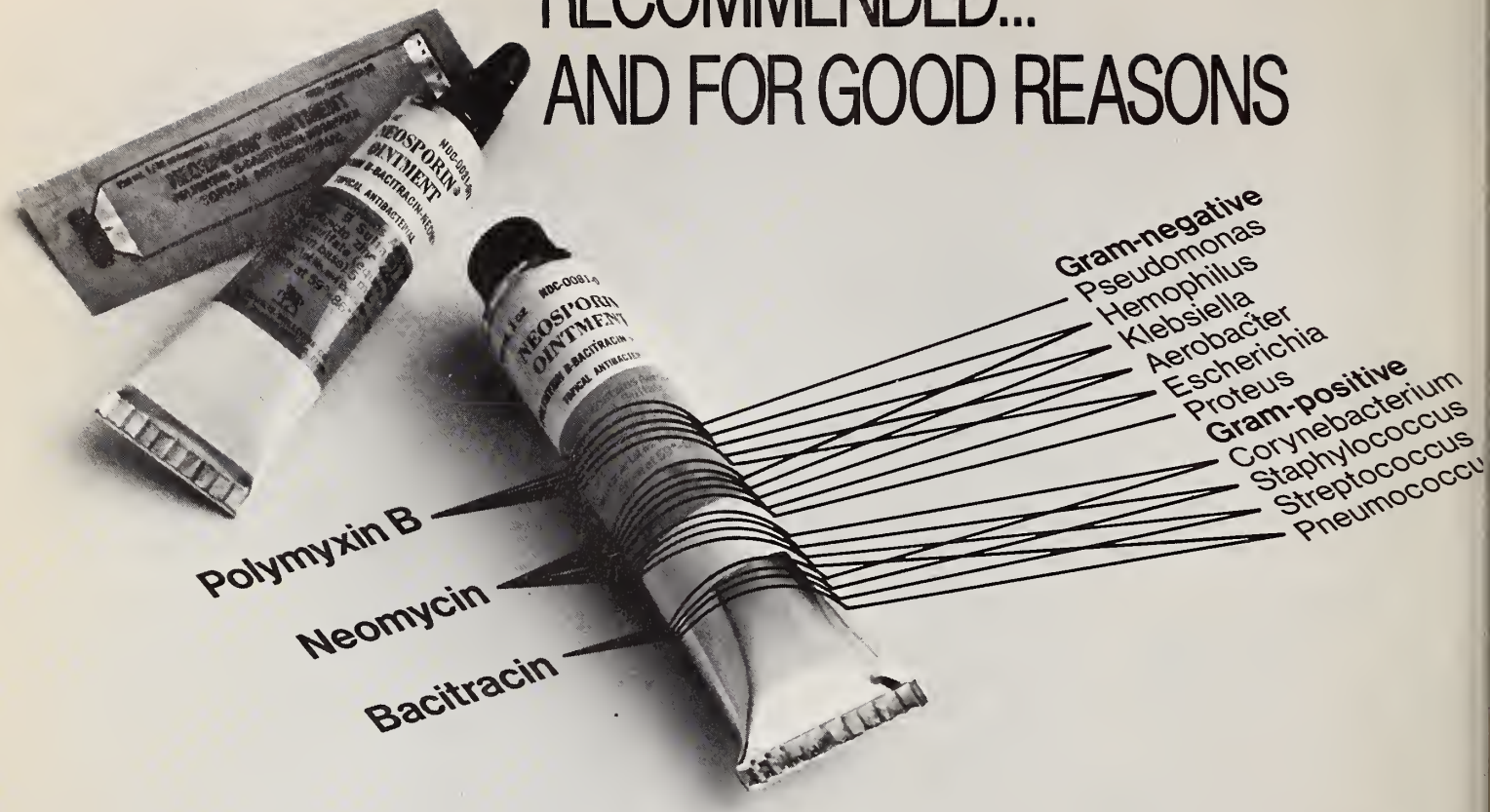
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The Challenge to Relative Value Guides Under the Federal Antitrust Laws: Round 1 Goes to the Physicians

ROBERT N. BERG, *Atlanta**

SINCE 1956, the medical profession has utilized "relative value guides" as an aid in determining the prices charged by physicians for various medical procedures. Recently, however, the use of these relative value guides has been challenged by the United States Department of Justice, both in several actions culminating in consent orders forbidding the use of relative value guides[1] and, for the first time, in a lawsuit which charged that the use of the relative value guides by the American Society of Anesthesiologists (ASA) and its component local societies constituted an unlawful scheme of price fixing in violation of the federal antitrust laws. While the United States District Court for the Southern District of New York rejected the government's challenge in the case of *United States v. American Society of Anesthesiologists, Inc.*,[2] and decided in favor of the anesthesiologists, it appears that this case may be only the beginning in what looks to be a long fight to determine the validity of the use of relative value guides under the federal antitrust laws.

Background

As a medical specialty, anesthesiology[3] was first developed in 1928 and grew considerably during World War II, when the government began requiring the use of anesthesia whenever possible. In the years prior to 1957, most anesthesiologists worked as salaried employees of hospitals; anesthesia was considered part of the hospital's services and was billed to the patients as such. By 1957, however, anesthesiologists began to establish independent practices and were able to obtain hospital privileges on the same terms and conditions as other clinicians.

The rapid growth of anesthesiology into a recognized medical specialty required an equally rapid development of methods for determining the fees charged by anesthesiologists. Not surprisingly, the initial methods by which the anesthesiologists determined the prices which they charged for their services were somewhat hastily constructed and oftentimes unsatisfactory. In many cases, the fees charged by anesthesiologists were fixed as a percentage of the surgeon's fee, a method which failed to take into consideration other factors such as the age and general health of the patient and the time required for the anesthesiologist to perform his or her services.

In 1961, the ASA, an organization composed primarily of physicians engaged in the practice of anesthesiology,[4] in an effort to quell the rising tide of dissatisfaction among its members over the methods by which the fees of its member anesthesiologists were determined, authorized the development of a relative value guide for anesthesiological services.

* Prepared at the request of the Medical Association of Georgia. Mr. Berg is an associate in the firm of Powell, Goldstein, Frazer & Murphy, General Counsel to the Association, 1100 C & S National Bank Building, Atlanta, GA 30303.

In general, a relative value guide is a list of medical procedures which are individually described in medical terminology and by reference to an abstract number known as a unit value. In constructing a relative value guide, the usual format is one containing two columns — one column describing the particular medical procedure, and the second column giving the number representing the unit value for that procedure. By comparing the various procedures and the values given to those procedures, it is thus possible to determine the relationship or relative value of one medical procedure to another.

Moreover, by dividing the unit value for a particular medical procedure into the usual fee charged by a physician for that procedure, a physician could derive a conversion factor, which, when multiplied by the unit value given to another medical procedure, could determine the usual fee for that second procedure. For example, if a physician's usual fee for a particular procedure is $25.00 and the relative value guide assigned five units for that procedure, the conversion factor would be $5.00. From this, the physician could determine that another procedure having a unit value of seven should be billed at $35.00, while a procedure having a unit value of two should be billed at $10.00. By repeating this procedure of multiplying the unit values times the conversion feature for a wide variety of medical procedures, the physician could construct an entire fee schedule.

In 1962, the ASA House of Delegates approved the relative value guide for anesthesiological services which the ASA had commissioned to be prepared in 1961 (the "Relative Value Guide"). The ASA Relative Value Guide was a document of 103 pages, listing the unit values for approximately 1,450 surgical procedures.[5] Its primary purpose was to provide assistance to local component anesthesiological societies and to individual anesthesiologists who participated in the development of local fee schedules.

Between 1962 and 1975, the ASA Relative Value Guide was modified on several different occasions, with new medical procedures added and with the unit values revised and updated. Each time, the Relative Value Guide was distributed by the ASA to local anesthesiological societies, to individual members and to various health insurance carriers, agencies of the federal, state, and local governments, educational institutions, and others.

The ASA encouraged its component societies to develop their own relative value guides, and did not employ formal or informal sanctions to discourage the component societies or individual anesthesiologists from independently determining their own fees on whatever basis they chose. In addition, the ASA did not employ formal or informal sanctions to encourage the use of uniform conversion factors, by which uniform fee schedules could be constructed.[6]

Round 1 — The Government Challenges the ASA Relative Value Guide

In the ASA case, the government argued that the ASA, its component societies and its members entered into a combination and conspiracy to fix, stabilize, and maintain the fees charged by ASA members, a *per se* unreasonable restraint of trade in violation of Section 1 of the Sherman Act.[7] In that context, the government charged that the ASA Relative Value Guide constituted an agreement among competitors to manipulate and tamper with the price structure for anesthesia services.

The Court first looked at the effect of the ASA Relative Value Guide on interstate commerce, in that the Sherman Act is inapplicable to wholly intrastate activities. In that regard, the Court recognized that the practice of anesthesiology is an intrastate one, with the administration of anesthesia and the payment of anesthesia fees by the patient being clearly local in nature.[8] Nevertheless, in light of the fact that the cost of anesthesia services has a significant impact on insurance premiums received from holders of insurance policies across state lines, and in light of the large portion of revenues received by anesthesiologists from health insurance carriers under the Medicare and Medicaid programs, the Court held that the use of the ASA Relative

Value Guide had a "substantial effect on interstate commerce"[9] and thus was subject to review under the federal antitrust laws.

Turning to the government's challenge that the ASA Relative Value Guide was being utilized to further a scheme of unlawful price fixing, the Court found that there was no evidence of any agreement to manipulate or tamper with the prices charged by anesthesiologists. While the Relative Value Guides were widely disseminated and employed by many anesthesiologists, the Court found that they were merely a *suggested* methodology for arriving at an appropriate fee in a given instance — that they were, as their name suggested, merely guides, which the individual anesthesiologists were free to adopt, modify, or reject.[10] Since the conversion factors were not included in the Relative Value Guides and were left to the individual practitioners, the Relative Value Guides could not be said to fix prices. Rather, they were merely the bare-bones of a pricing schedule which gave the individual anesthesiologists a logical starting point for negotiating with the actual payors of their fees — the health insurance carriers. Consequently, the Court held that the use of the ASA Relative Value Guide was not a *per se* violation of the Sherman Act.

Although not required under the federal antitrust laws, the Court, because the ASA case was one of "first impression,"[11] also analyzed the use of Relative Value Guides under the "Rule of Reason," an analysis under which the Court weighed all of the circumstances in order to determine the pro- and anti-competitive aspects of the particular restraint involved (in this case, the Relative Value Guide). In that regard, the most important aspect of the Court's analysis dealt with what the Court termed the "unique" market for anesthesia services, in that anesthesiologists, unlike other medical specialists, rarely have contact with patients prior to their surgery, and in most cases do not discuss fees with the patients. Rather, the anesthesiologists' fees are normally determined as a result of negotiations between the anesthesiologist and third-party payors such as insurance carriers. Consequently, the Court found that there was little if any competition among anesthesiologists insofar as patients were concerned.[12]

As for the economic market involving the interchange between the anesthesiologists and the third-party payors, the Court admitted that the use of Relative Value Guides "tended to affect the formation of prices." On the other hand, however, the Court noted that there was no evidence of the ASA coercing the third-party payors into accepting the Relative Value Guides. Indeed, the Court found that the use of the Relative Value Guides by the individual anesthesiologists served to promote, rather than pervert, the interplay of competitive forces between insurance carriers and anesthesiologists. Thus, under the "Rule of Reason" analysis, the Court also upheld the use of Relative Value Guides as not constituting a violation of the federal antitrust laws.

Round 2?

While the Court's decision in the ASA case certainly should be construed as a victory for the use of relative value guides, it can by no means be considered as an end to the government's challenge to the use of these guides under the federal antitrust laws. The unique nature of the market for anesthesiological services is clearly a means for distinguishing between that medical specialty, on the one hand, and the general medical profession, on the other. As noted by the Court in the ASA case, anesthesiologists, unlike other physicians, deal almost solely with insurance carriers, do not compete for patients, and in fact do not normally even see their patients until shortly before the performance of their services. Consequently, while the ASA case highlights the beneficial aspects of the use of relative value guides, it cannot be said that the use of these guides by physicians who deal with patients on a daily face-to-face basis would fare equally as well as did the use of these guides by anesthesiologists. In that regard, while only time will tell whether or not the medical profession can win Round 2 in its battle over the use of relative value guides, it can be said with relative certainty that there will be a Round 2.

Notes

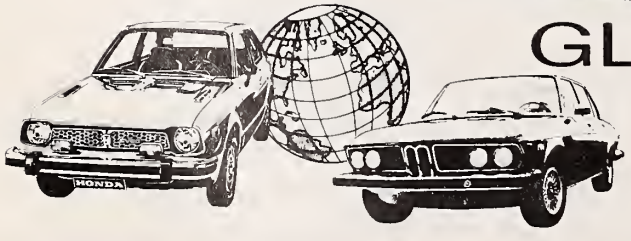
1. On Sept. 13, 1977, the Justice Department obtained a consent decree whereby the Illinois Podiatric Society agreed to stop developing and circulating relative value guides or studies. Similar consent decrees were obtained by the Federal Trade Commission against the California Medical Association (Apr. 17, 1979), and the Minnesota State Medical Association (Oct. 31, 1977).
2. 473 F.Supp. 147 (S.D.N.Y. 1979).
3. As most of you are probably aware, anesthesiology is a medical specialty which deals with the management of procedures for rendering a patient insensible to pain during surgical, obstetrical, and certain other medical procedures; the support of life functions under the stress of anesthetic and surgical manipulation; the management of problems in cardiac and respiratory resuscitation; the application of specific methods of inhalation therapy; and the clinical management of various fluid, electrolyte, and metabolic disturbances. 473 F.Supp. at 149-150.
4. At present, the ASA has approximately 14,000 members, about 70% of which are licensed physicians engaged in or interested in the medical specialty of anesthesiology.
5. 473 F.Supp. at 153.
6. 473 F.Supp. at 158-159.
7. Under a *per se* analysis, the inquiry by the Court is limited to that of determining the existence of the particular restraint alleged to violate the antitrust laws; once such a determination is made, a *per se* violation has been established, without any inquiry into the reasonableness of the restraint.
8. 473 F.Supp. at 156.
9. See, e.g., *Hospital Building Co. v. Trustees of Rex Hospital,* 425 U.S. 738, 96 S.Ct. 1848, 48 L.Ed. 2d 338 (1976).
10. 473 F.Supp. at 160.
11. 473 F.Supp. at 159.
12. 473 F.Supp. at 160.

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Christmas and Love, A Way of Life for All Seasons

The affirmative of affirmatives is love.
R. W. Emerson:
Success, 1877

Time
is
Too slow for those who wait,
Too swift for those who fear,
Too long for those who grieve,
Too short for those who rejoice,
But for those who love, time is
Eternity.
Hours fly,
Flowers die,
New days,
New ways,
Pass by.
Love stays.
Anon.: Inscription on a sundial at the University of Virginia, Charlottesville

REGARDLESS of one's religious persuasion or lack thereof, most informed persons are agreed that there occurred about 2,000 years ago a very significant event, the birth of Jesus Christ. Born in very humble circumstances, this person exhibited unusual spiritual maturity from a very early age. While following his father in the carpentry trade, he astounded his elders, among whom were very learned men, with his insight into the basic truths of life. Historically, his active ministry began after he was 30 years of age and ended with his crucifixion 3 years later.

Few would deny that the impact of his brief ministry has been without parallel in recorded history. His message was straightforward and without compromise. His message was full of joy and reassurance. His message outlined in unmistakable terms the purpose of our being. The essence of life at its most fulfilling and happiest level is the good news about love that Christ taught.

Love in its ultimate form involves a wide spectrum of elements. To use Henry Drummond's analogy, if we could take love and pass it through a crystal prism as if it were a beam of light, we could then see its component elements. We would have, as a result, a spectrum of love. These elements have common names: patience, kindness, generosity, humility, courtesy, unselfishness, good temper, guilelessness, and sincerity. All of these are in relation to persons, in relation to life, in relation to the known today and the near tomorrow, and not to the unknown eternity. These are ordinary virtues which can be practiced by every man and woman in every walk of life. When coordinated together within a person, they make up love in its only true and valid form.

Religion, then, is not a strange or added thing but an inspiration of the secular life, the breathing of an eternal spirit into this temporal world. The supreme thing, in short, love, is not a thing at all but the giving of a further finish to the multitudinous words and acts which make up the sum of every common day.

Thank God for sending this person, whose birthday we celebrate, to live among us as a demonstration of the ultimate that life offers for each of us. Let us reevaluate and reaffirm the role that love occupies in our lives.

Edgar Woody Jr., M.D.

ROBERT SOUTHWELL (1561-1595)

Father Robert Southwell, S.J., was the younger son of a prominent English family who went to the English seminary for Catholics at Douai as a youth, then to Rome, where he entered the Society of Jesus. In 1586 he returned to England. His mission was a dangerous one, and he probably foresaw the martyrdom he was to suffer in 1595. He wrote a good deal of religious prose and verse; the most famous of his lyrics is *The Burning Babe*. Ben Jonson remarked to William Drummond of Hawthornden that if he had written *The Burning Babe* he would have been willing to destroy many of his own poems.

The Burning Babe

As I in hoary winter's night stood shivering in the snow,
Surprised I was with sudden heat which made my heart to glow;
And lifting up a fearful eye to view what fire was near,
A pretty babe all burning bright did in the air appear;
Who, scorchéd with excessive heat, such floods of tears did shed
As though his floods should quench his flames which with his tears were fed.
"Alas," quoth he, "but newly born in fiery heats I fry,
Yet none approach to warm their hearts or feel my fire but I!
My faultless breast the furnace is, the fuel wounding thorns,
Love is the fire, and sighs the smoke, the ashes shame and scorns;
The fuel justice layeth on, and mercy blows the coals,
The metal in this furnace wrought are men's defiléd souls,
For which, as now on fire I am to work them to their good,
So will I melt into a bath to wash them in my blood."
With this he vanished out of sight and swiftly shrunk away,
And straight I calléd unto mind that it was Christmas day.

Tips From The St. Paul to Prevent Medical Malpractice Claims

Did you know . . . that you can be sued for what you did or what you did not!

One simple procedure that goes awry, for whatever reason, can lead to malpractice allegations.

Your professional ethics, skill, and good judgment will be your best guide towards prevention but here are a few tips gleaned from the St. Paul's claim files and from their years of experience in handling malpractice matters.

Communications

It is important to be sure the patient *and* his family understand the procedures you contemplate and what the possible negative consequences might be, as well as the hoped-for remedial results. A few extra minutes with a patient can be well worthwhile in avoiding misunderstandings that could arise later.

Instruct and caution your patient about medication dosages, and cover thoroughly any condition requiring extraordinary care.

A doctor can be held liable for the negligence of his medical partners or employees. Insist upon accuracy in all labeling and in recording of your instructions to nurses or subordinates in hospitals or office. Be sure they understand the operation and hazards of any equipment they are given to use.

Be sure telephoned and other verbal instructions have been entered in the patient's record. When it is necessary to give orders to the hospital over the telephone, check and initial them immediately upon your arrival there.

Beware of loose talk . . . make no adverse criticism of care or treatment a patient has received from another — unless you have full knowledge of the facts from all the parties, from the doctor who treated the patient as well as from the patient. Many competent defense lawyers believe that a high percentage of malpractice cases would be averted if criticism of previous treatment were stopped.

Fee disputes and unusual collection methods have precipitated many malpractice claims.

Informed Consent

It is a medical communications service for doctors to explain to their patients the nature, benefits, risks, and alternatives of specific medical procedures. The fact that he came to you for treatment implies consent to routine physical examinations, taking of blood samples, etc. You should, however, document in his record your discussions or instructions to clearly establish that he knows what procedures were undertaken.

A doctor must inform his patient of the general nature of a procedure to be performed so the patient may make an intelligent decision to accept or reject such treatment. He must be advised of significant and serious risks as opposed to remote dangers and minor consequences.

Elective sterilization requires written consent of the spouse.

Consent of parents or legal guardian must be obtained for treatment of a minor.

Obtain written consent before you begin any surgical operation, treatment, or autopsy. Remember, surgery performed beyond the consent obtained constitutes assault.

Examinations

Always make thorough and complete examinations, utilizing available laboratory facilities.

Be certain that you record a patient's sensitivities or adverse reactions to drugs or medications.

Keep a nurse or office assistant present while examining a female patient. Prohibit the presence of laymen.

Equipment

Equipment in hospitals and offices must be maintained in perfect condition at all times.

Cleanliness and sterilization of instruments should be routine.

Keep an accurate count of sponges, clamps, retractors, etc. used in surgery.

Guarantee

Do not promise or guarantee a cure as a result of any special operation, medication, or course of treatment . . . too many factors over which you have no control may modify the outcome. Reassurance of the probabilities of a satisfactory outcome can be accomplished without guaranteeing a cure.

Keep Current

Keep up-to-date on new treatments and techniques; read approved medical publications, attend scientific meetings, and keep yourself informed on today's scientific developments in medicine.

BUT — do not use or recommend any fad or unproven method of treatment.

Records

Complete, accurate, and up-to-date records must be kept on all patients. Medical history, former physicians,

and their treatment should be included. It is important to record all prescriptions and refills, and be sure they are checked before each telephone authorization.

Consultants

Should you have doubt concerning any surgical procedures, diagnosis, or method of treatment, don't hesitate to seek another opinion. Call in a specialist, perhaps you and your patient will both benefit from his expertise, and it is a precaution for your protection should there be some unfortunate eventuality.

Exercise care in the selection of consultants and assistants and in the delegation of duties to them.

Safety

Make DOUBLE CHECK a habit for yourself and your assistants of all medication, blood, anatomy — *everything* — before administration or surgery to be sure the right treatment is administered to the right patient.

Cooperate with safety procedures and rules set up by Hospital Administrators and staff.

When using flammable anesthetics, permit only electrical instruments and apparatus which are U.L. listed for hazardous locations.

Labeling

All drugs, preparations, blood and other specimens — again *everything* — must be accurately and promptly labeled.

Abandonment

Never abandon or neglect a patient (even if you feel you have good reason) unless timely and firm notice has been given. If you are to be away or out of reach, provide access to a qualified substitute.

If a Patient Indicates Dissatisfaction:

1. Be careful with your conversation. You can be sympathetic but *do not* be committal.
2. Inform your insurance carrier. Don't wait for a lawsuit or threat of lawsuit to notify the insurance company.
3. If a lawsuit appears likely, collect and review all related records.
4. Be honest and open with your attorney and insurance company. Favorable and unfavorable facts should be discussed.
5. Do not attempt to practice law — your insurance company and its legal staff are experienced and prepared to help.

An Urgent Ethical Challenge

Medical ethics, like medicine itself, steadily gains new dimensions and presents us with new challenges. Today, no challenge is greater or timelier than the deceleration of health-care costs. And it's truly an ethical challenge.

Considerateness for the bills that patients pay is integral to respecting patients as human beings. And that respect is where ethics begins.

Valuable guidance in carrying out the cost ethic is provided by the report of the National Commission on the Cost of Medical Care that the AMA sponsored.

All of us, and each of us, must take it upon ourselves to activate the Commission recommendations that have been approved by the AMA House of Delegates. We must make them an organic part of the daily consciousness and conduct of our profession.

Let's consider three of the recommendations as examples.

First, we must stimulate in our own ranks, in hospitals, and among our patients an effective realization of health-care costs and their impact on the system of care.

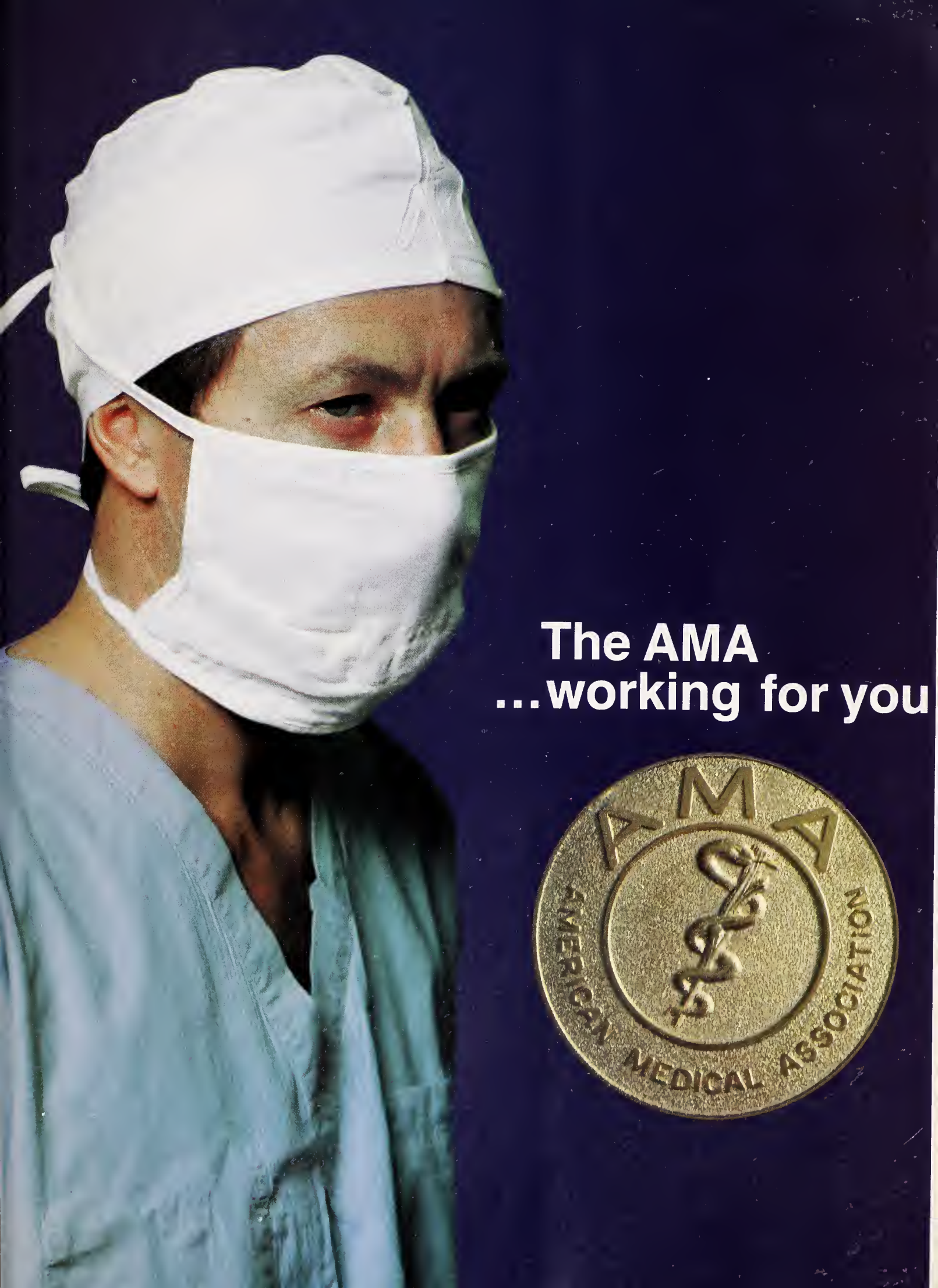
Second, we must urge intensified efforts to discipline those physicians who are found to be defrauding or abusing the health-care financing or delivery system. Also, we must enable more physicians to realize they have an ethical responsibility to report a colleague's misconduct. We cannot protect a wayward colleague without violating our own sworn duty to protect the patient.

Third, we must encourage intensified research toward a basic understanding of disease, and the most appropriate treatment thereof, within the context of today's urgent need for cost containment.

It must be stressed, however, that if we are to exert a maximum good influence on ethics and other growing issues, our Association must maximize its physician representation from all segments of our profession.

Every physician in this land has a membership in the problems that the Association copes with in his or her behalf. So let's have fuller membership in the Association and its solutions.

(Memorandum from the Office of Public Relations, American Medical Association, Chicago, Illinois.)


The AMA
...working for you
AMA
AMERICAN MEDICAL ASSOCIATION

Imagine...

Little more than a century ago medical practice was groping through darkness. Surgeons limited themselves to simple operations. Many of those who practiced medicine did so without a formal medical education. Diploma mills did a landslide business in competition with the few legitimate medical schools. There was little formal licensing. Since physicians could do little to treat most diseases, people often sought relief from quacks, cultists, and faith healers.

Among the competent and dedicated physicians there was an acute awareness and concern about the state of the public health and the quality of medical care. In 1847, 250 of these physicians met in Philadelphia to form a national association –the American Medical Association–whose purpose remains the same firm commitment today: *to promote the science and art of medicine and the betterment of the public health.*



Protecting Your Rights And Interests

One of the AMA's major functions is to act as the advocate for physicians' rights and for the quality of patient care. Effective representation is critical because of the federal government's mounting pressure for tighter regulation and control of medicine.

Every year, the AMA monitors, analyzes and reports on thousands of pieces of health-related legislation and regulations—at both the federal and state levels. To meet specific legislative needs in the health area, the AMA has drafted its own bills.

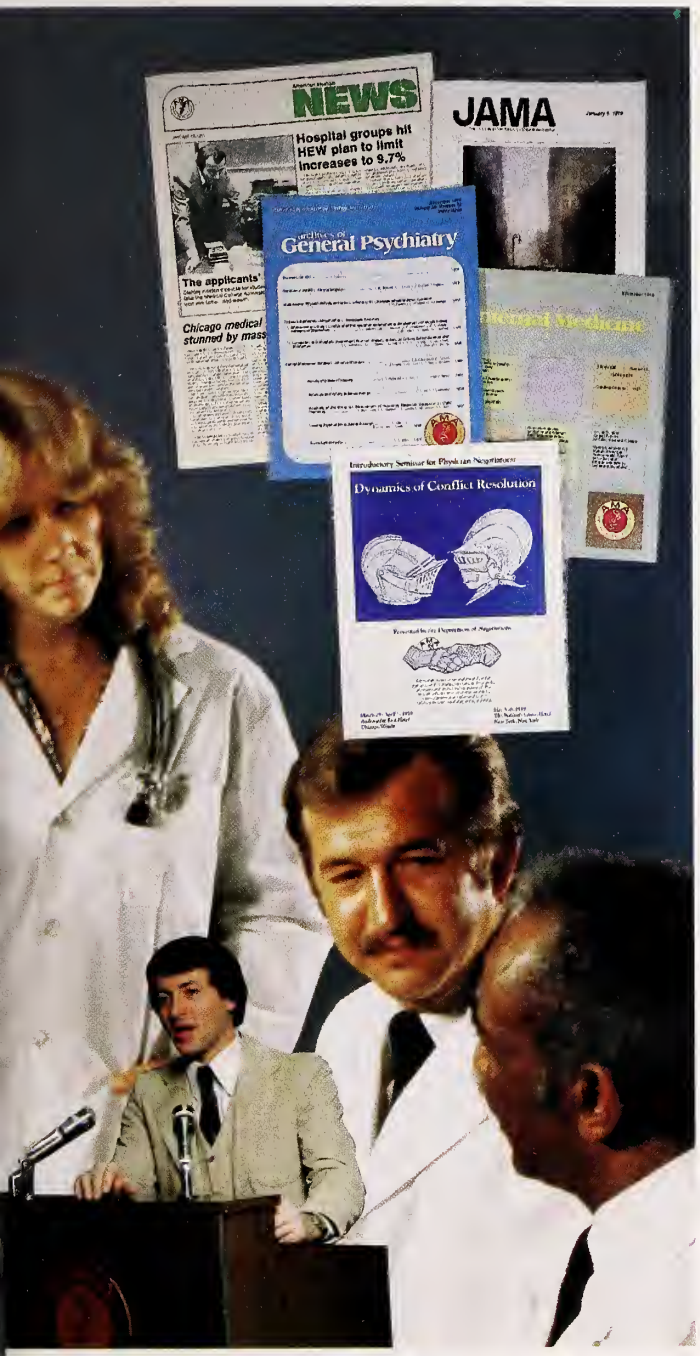
AMA officers and trustees frequently testify before Congressional committees and federal agencies. During the 95th Congress, the AMA submitted formal, written testimony or furnished witnesses to testify more than 200 times on bills and regulations affecting health care delivery. And, on several occasions, it has been necessary for the AMA to take the government to court. In fact, the AMA spent over $1,000,000 in 1978 on legal fees to defend the rights of physicians and patients.

Here are examples of the AMA representing your interests before Congress and governmental agencies:

- The AMA is challenging an FTC administrative judge's initial decision that the AMA cannot establish ethical guidelines on physician advertising and solicitation.
- The AMA is defending three antitrust suits (filed by chiropractors) to preserve medicine's First Amendment rights to speak out on public health issues concerning physicians.
- The AMA worked with hospital groups to defeat the Carter Administration's proposal for rigid cost controls on hospitals which would have adversely affected the quality of care.
- The AMA defeated proposals for federal licensure and re-licensure.

The AMA is also involved in projects to improve rural, inner-city, jail and emergency care; encourage family practice in medicine; curtail TV violence; and the Auxiliary's campaign to promote adequate immunization among the millions of our youngsters.





Your Membership Benefits

AMA membership provides you with a broad range of both professional and personal benefits and services. Among them are:

PUBLICATIONS

Journal of the American Medical Association—To help you keep on top of the latest scientific developments every week.
American Medical News—Provides the latest information on events and personalities affecting the practice of medicine.
Specialty Journals—For specific scientific information in your specialty, you have a choice of one of nine specialty journals.

Members Insurance Programs

AMA insurance programs provide substantial coverage at a cost considerably lower than what you would have to pay on an individual basis. The programs available are: Group Life Insurance, Excess Major Medical, Disability Income Insurance, Supplemental "In Hospital" Insurance, Accidental Death and Dismemberment Plan, and Office Overhead Expense Insurance.

Seminars

Negotiations—Designed to help physicians develop and improve their negotiating skills.
Practice Management—Provides proven guidelines for effective and productive management of the physician's practice. Includes physical plant, personnel, procedures, and patient relations.
Speakers Training—Instructs physicians in the methods and techniques of effective public speaking.

Additional Membership Benefits

- The nation's largest physician placement service.
- CME programs—expanded and regionalized to make continuing medical education more convenient and less expensive.
- The research resources of one of the nation's most up-to-date medical libraries.



The AMA—The Standard-Bearer Of Excellence

Since its inception, the AMA has provided the leadership which has led to the excellence of medical education and the high quality of medical care in this country. No other single organization has assumed such major responsibility for the establishment and maintenance of these standards of excellence.

The AMA participates jointly with other organizations to ensure high quality in both medical education and health care delivery. This is accomplished through the accreditation of medical schools, hospitals, residency training programs, allied health professions training programs, and institutions offering continuing medical education.

Physicians can be secure in the knowledge that hospitals, and allied health professionals have been subjected to stringent training and qualifying standards. If the AMA did nothing more than serve as guardian of the educational standards of the profession, it would deserve the support of all physicians.

Where Your Dues Dollars Go

Represent the Medical Profession: 14% — To represent and serve as an advocate for the medical profession in its relations with state and federal legislative bodies and regulatory agencies. Also includes development of public relations and negotiations programs, and communications with the profession.

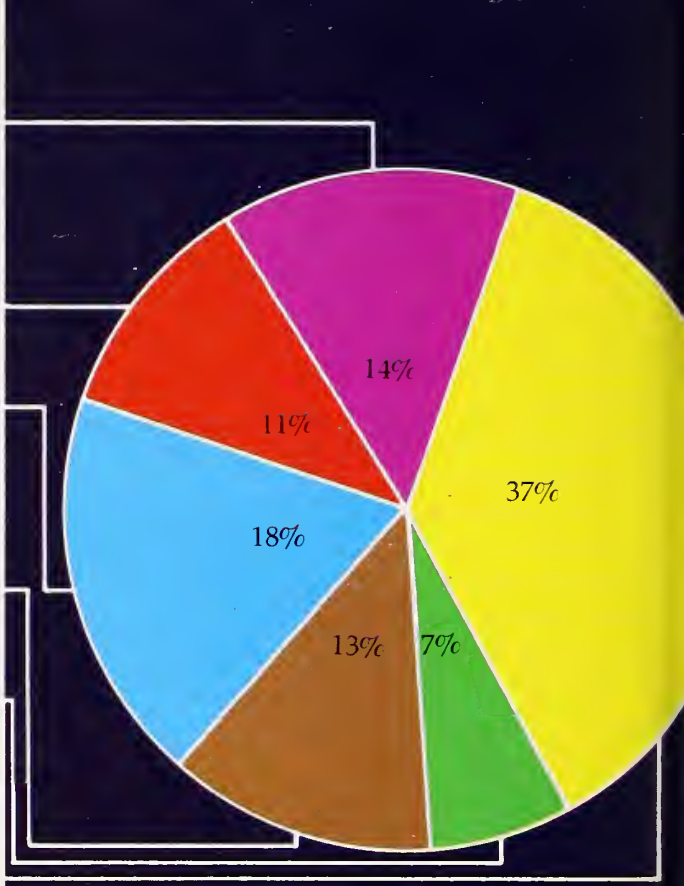
Strengthen Organized Medicine: 11% — Membership development, membership benefits and services, improved relations with and services to medical and specialty societies.

Assure and Continue to Improve the Quality of Medical Care: 18% — Accreditation of undergraduate and graduate medical education, development of continuing medical education programs, certification of physician credentials, and evaluation of the quality of medical care.

Internal Support Service Programs: 13% — Financial, planning, legal, personnel, data processing, and administrative services for the Association.

Promote the Effective Delivery of Care: 7% — Development of programs for health manpower, community health care, practice management, physician-hospital relations, health care financing, and health delivery research.

Scientific Policy and Information: 37% — Publication of scientific journals, dissemination of health information to the public, development of scientific policy, investigation of scientific concerns, such as nutrition, drugs, environmental and occupational health, and hypertension.



The AMA Needs Your Support

Membership in all levels of organized medicine is an essential component of professional citizenship and like political citizenship, should not be fragmented. Do you want a voice in government only at the city and county levels? Only at the state level? Or only at the national level? Certainly you would feel disenfranchised if you were deprived of a voice on any of these levels.

Citizenship and membership—both political and professional—is not without cost. Your dues, the cost of professional citizenship, are needed at all levels—your county and state society and the AMA—so that organized medicine can remain an effective organization working for you.

If You're Not An AMA Member, Here's How To Apply

Regular Membership—Physicians, including housestaff, and medical students who are members of their state medical societies or who are eligible for state society membership are required to join the AMA through that society. Simply contact your local medical society. (If you do not have this information, write the Department of Membership Development, AMA, and the name and address of your local society will be sent to you.)

Direct Membership—Physicians, including housestaff, and medical students who are not provided with an avenue for regular active membership through their local society due to limitations or bylaw restrictions of that society may join the AMA as direct members. To join, use the application enclosed.

Transfer Membership—An AMA member who moves from one medical society to another may maintain or renew membership while application is pending in the new medical society.

Dues

Physicians	$250	Interns, Residents	$35
First Year Practice	$125	Medical Students	$15

If you are an AMA member, you should be justifiably proud of what your suppo has helped the AMA accomplish.

If you are not a member, isn't it time you did your share to support your profession? Join the AMA now. It needs you—your membership and your active participation.



Department of Membership Development
American Medical Association
535 North Dearborn Street
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heart page
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Coronary Bypass — The Postoperative Challenge

ARTHUR J. MERRILL JR., M.D., *Atlanta**

PATIENTS with angina and other symptoms of coronary disease are having coronary bypass surgery with increasing frequency — over 100,000 operations were done in the United States in 1978. Initial results are now excellent in many centers across the country. Long-term survival is also improved in certain subsets of patients.

Thanks to new techniques for myocardial preservation and increased surgical expertise, operative mortality is now 1% or less; and perioperative infarctions occur in less than 5% of patients. Most patients go home about 1 week after surgery. Ninety percent are improved, and 70% are angina free postoperatively. On re-catheterization, 90% of the grafts are patent early postoperatively. Only a few patients still have protracted hospitalization and/or long-term problems with arrhythmias, angina, or congestive failure. But what about long-term morbidity? What about work records post bypass? What about the cost and the late recurrence of angina?

Long-Term Problems and Successes

Long-term follow-up (Table 1) has shown that mortality is improved by surgery in left main disease and probably also in triple vessel disease. In fact, survivals in these groups differ from age matched population by only about 1% per year. Unfortunately, infarctions still occur in 1-4% of patients yearly. Angina is present in 18% of patients after 1 year.[3] Even more troublesome is the late recurrence of angina in 35-40% of the patients originally free of angina postoperatively.[4, 5] Angina that recurs in the first year after the operation is generally due to graft closure; thereafter, in ¾ of those with recurrent ischemic pain, the cause is progression of disease in native vessels.[4, 5]

Table 1

Long-Term Follow-Up of Patients With Angina — 5-Year Survival, Atlanta, Georgia

(1) Number of Vessels Diseased	(2) CABG*	(3) Medical (VA)	(4) General Population
One	94-96%	94-96%	95%
Two	93%	87%	95%
Three	89%	74%	94%
Left Main	87%	61%	94%

*** CABG — Coronary Artery Bypass Grafting. Column (1) is number of coronary vessels 70% narrowed. Column (2) is 5-year survival in surgical patients from the U. of Alabama quoted in Hatcher.[8] Column (3) is survival in medical patients from VA Cooperative Study.[9] Column (4) is the survival rate in a general population (U.S. Census) that has been age and sex matched to the patients in Column (2), again quoted in Hatcher.[8]**

* Dr. Merrill is the Director of the Cardiac Catheterization Laboratory at Piedmont Hospital. Address reprint requests to him at Piedmont Hospital, 1968 Peachtree Rd., NW, Atlanta, GA 30309.

Articles for this page are prepared at the request of the Physician Education Committee of the American Heart Association, Georgia Affiliate, Broadview Plaza, Level C, 2581 Piedmont Rd., NE, Atlanta, GA 30324.

Cost — Medical vs. Surgical Treatment

Much has been said about the cost of bypass surgery. If it returns people to productive work or allows them to continue work, this cost to the economy is quickly repaid. Let us investigate cost for a moment. In general, bypass surgery and all accompanying diagnostic procedures cost $10-12,000. A study from the University of Alabama has shown that one half of the patients with unstable angina treated medically have surgery later because of intractable symptoms. In this group, the total cost including surgery is approximately $20,000. Most patients with unstable angina and two or three vessel disease eventually underwent surgery.[7] The follow-up of another group of patients, half treated medically and half having bypass surgery (matched for angina, left ventricular function, and extent of coronary disease) reveal that the medical group had 60% more hospitalizations in the subsequent 2 years.[6] Both of these studies suggest that medical costs may be higher in symptomatic patients with two or three vessel disease treated medically than in those having operations.

Another concern is that only 50% of the patients go back to work after surgery. The most important predictive factors correlated with return to work appear to be pre-operative employment status, age, and if retired preoperatively — how long? Self-employed people and professionals have a higher rate of return to work than salaried employees. Patients off work less than 1-2 months preoperatively also have a high rate of return to employment. Follow-up of 394 men under 55 years of age working prior to surgery showed that 87% returned to work, and 85% were still working 5 years postoperatively.[1] It appears that the decision to send the patient with significant angina to surgery should be made while he is still working or disabled for only a short time.

If the above data are true for bypass patients in general, what are our responsibilities to our patients with angina? Clearly, symptomatic patients who have left main and triple vessel disease need to be identified, and most will benefit from surgery. Patients with angina which is resistant to medical therapy and double or triple vessel disease should probably also be referred for relatively early surgery. This will avoid higher medical costs and return them to productive activity quickly. This is especially true of younger patients who have families to support.

But once surgery is over, physicians have an even greater obligation to these patients. Most patients do not know that the surgery is palliative and not a cure. They must be told. All patients who smoke must stop — to continue to do so will triple the incidence of progression of their atherosclerosis. Hypertension must be rigorously controlled — getting blood pressure down to 140/90 or preferably even lower. Diabetics should have their blood sugar as well controlled as possible. All patients should get down to their ideal body weight. Patients who can do so should be encouraged to return to work as soon as they are able, usually about 6 weeks to 2 months postoperatively, unless their job involves a lot of lifting. In this instance, they should wait longer, perhaps 3 to 4 months, to let the sternum heal completely. There is general agreement among most cardiologists about these things.

More controversial are the roles of lipid reduction, antiplatelet agents, and regular exercise in the prevention of progression of atherosclerosis. I personally put all post bypass patients on aspirin 300 mg. b.i.d. unless there is contraindication. Aspirin not only has an antiplatelet effect, but also raises the threshhold for ventricular fibrillation. Anturane in a dose of 200 mg. t.i.d. has been shown to decrease sudden death in patients with myocardial infarction and has the same action on platelets as aspirin, but it is much more expensive.

Exercise has many beneficial effects, even if it does not slow progression. In my opinion, most patients should exercise regularly either under supervision or with friends 3 times a week. This should not be done until an exercise stress test shows that it is safe. This type of exercise will help in weight reduction, an improved sense of well being, and increase HDL cholesterol — the lipoprotein that removes cholesterol from tissue.

What about lipid control? Most studies have shown little benefit of lowering lipids in prevention of recurrent coronary events. However, the studies are of relatively short duration, and cholesterol was usually not reduced more than 25%. Animal experiments show that cholesterol must be reduced to very low levels to achieve regression or lack of progression of atherosclerotic lesions. These levels are usually below 150 mg. and are difficult to reach with usual dietary precautions. They require very rigorous dietary control. Most late recurrences of angina are due to progression of atherosclerosis and occur at a rate of about 7% a year. For this reason, I feel that vigorous diet and even drug therapy for lipid control are indicated to lower cholesterol. I put most of my patients who are less than 60 years old on a vegetarian diet (avoiding most dairy products as well except soft cheeses and skim milk). I actively try to get their cholesterol down to below 150 mg.% if possible. This is very difficult for most Americans, but with support and encouragement from their physicians, many are able to do it. Good vegetarian cookbooks are available, so food can be made palatable and enjoyable. This also helps their families become accustomed to eating a lower cholesterol diet. Vitamin supplements may be needed because of low levels of fat soluble vitamins. By treating all atherogenic risk factors vigorously, I hope to reduce the recurrence rate of symptomatic coronary disease in post-bypass patients.

Summary

Bypass surgery is now a safe, successful, and widely used operation to treat angina. Symptomatic patients who find it difficult to continue their work probably need surgery before they become disabled for more than 1-2 months if they are to return to work. This may actually involve less expense then delaying surgery because of repeated hospitalizations and will avoid other medical costs in symptomatic unoperated patients with two or three vessel disease. Life expectancy is improved by surgery in left main and probably in triple vessel disease. Angina recurs post bypass at a rate of 7% a year. Rigorous control of risk factors postoperatively is one of the physician's most important and most difficult tasks because the patients feel so well. However, this must be done in order to try to prevent progression of atherosclerosis — the most common cause of recurrence of angina late postoperatively. A partnership relation between physician and patient is most important in this time of major change in the patient's life style.

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Tumor Regression by Differentiation of Malignant Cells to Benign States

BALDEV B. SINGH, D.D.S., M.S., Ph.D., and
RALPH V. McKINNEY, D.D.S., Ph.D., *Augusta**

THE CLINICAL evidence for spontaneous regression of certain cancers in humans is well documented. Although many of these regressions can be attributed to such factors as immune responses, hormonal, or psychic influences, there are now a number of well-documented cases in humans where regression involves cancer cells which have lost their malignant properties by undergoing differentiation to benign states. This phenomenon has been referred to as "benign differentiation."

This clinical observation has led many investigators to try to identify the endogenous or exogenous factors that are involved in the mediation of cellular differentiation in normal cells; and, taking it one step further, to try and determine which of these factors may influence differentiation in malignant cells. Some of the tumors currently being studied include teratocarcinoma, neuroblastoma, leukemia, squamous cell carcinoma, and others. Investigations indicate that neoplastic cell lines from these tumors do exhibit a potential for differentiation, thus confirming the concept that malignant cells can be induced to mature in a manner similar to their normal counterparts. For example, single teratocarcinoma cells undergo normal differentiation after injection into blastocysts. Malignant neuroblastoma cells can differentiate into benign ganglioneuroma cells, even exhibiting extensive neurite formation. In other tumors, the neoplastic cells undergo differentiation resulting in the production of a normal cell product such as orthokeratin, which is similar to what is seen in the normal maturing cell. This latter phenomenon is seen in the keratin pearl of squamous cell carcinomas.

In squamous cell carcinomas, perhipheral cells of the keratin pearl exhibit malignant features. If one follows the ultrastructural features of the tumor cells toward the center of the pearl, however, a gradual alteration in their morphology can be observed that is reminiscent of the normal differentiation pattern of epithelial cells involved in keratin production. Tritiated thymidine studies of these pearls show that in initial stages of pearl formation there is abundant mitotic activity throughout the pearl. With additional tumor growth, however, the thymidine label is confined primarily to the peripheral cells of the pearl, confirming the ultrastructural observations that the center and mid-zones of the pearl have lost their mitotic potential. A further confirmation of this concept of benign differentiation of neoplastic cells is that when undifferentiated carcinoma cells are transplanted, they develop into a malignant tumor in the host. When carcinoma epithelial pearl cells are transplanted, they do not produce malignant tumors.

* Drs. Singh and McKinney are professors at the School of Dentistry, Department of Oral Pathology at the Medical College of Georgia. Direct reprint requests to Dr. Singh, School of Dentistry, Dept. of Oral Pathology, Medical College of Georgia, Augusta, GA 30901. Prepared at the request of the Georgia Division, American Cancer Society. Others wishing to contribute papers to this page are invited to send them to David B. Roberts, M.D., 2400 13th St., Columbus, GA 31906.

Attempts to identify the various endogenous or exogenous factors which might influence this type differentiation of malignant cells has led to the study of the cyclic nucleotide system, prostaglandins, 5-bromodeoxyuridine, nerve growth factor, steroid hormones, macrophage-granulocyte inducer, epidermal growth factor, and others. Some of these factors have been shown to be effective in the induction of benign cell differentiation. Nevertheless, the relationship between malignant transformation and benign differentiation is very complex, and further studies are needed to explore the nature of these phenomena. Better understanding of this unique biologic observation may help bring about new treatment modalities. For example, the ability to induce benign differentiation in a metastatic carcinoma could provide an alternative to cytotoxic chemotherapy.

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president's letter



There's More Than One Way to Skin a Cat

I AM HEARING more and more criticism of the American Medical Association (AMA) as I visit our colleagues over the state. It is not always the same item under attack, but recently our positions on ethics and chiropractics have become priority topics. I am also told that, "The AMA does not represent me, and I think I will quit." Quitting is certainly one way to skin a cat.

You and I are the American Medical Association in Georgia. We have 3,662 members, which gives us four delegates and four alternates. Our delegation has much influence nationally, and in many ways the AMA is coming around to our philosophy. We have true leadership as evidenced by Harrison Rogers, Jr., M.D., vice-speaker of the AMA House of Delegates.

Our membership in the AMA is at an all-time high as well as our MAG membership — 4,720. If one-third of our non-AMA members joined, we would increase our delegates and alternates to five each. We can increase our AMA delegation 20% with only 339 new members. So encourage your colleagues who are not members to join soon.

I am also extending a personal invitation to you to attend the interim session of the AMA House of Delegates in Honolulu from December 2-5, 1979, and to speak at any reference committee on any item. This is the positive approach, and it is also the best way to skin the AMA cat.

Sincerely,

Earnest C. Atkins

Earnest C. Atkins, M.D.
President, MAG

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PERSONALS

First District

A portrait of **Arnold P. Mulkey Sr., M.D.,** honoring his 44 years of medical practice in Millen and Jenkins County, was unveiled at a dinner held for Dr. Mulkey at the Rogers Club House September 25. The portrait will be hung in the new Jenkins County Hospital.

Third District

George Armstrong Jr., M.D., of Columbus, was recently notified of his certification by the Sub-Board of Pediatric Cardiology of the American Board of Pediatrics.

On September 14, the Perry Hospital Staff and the Hospital Authority honored **A. G. Hendrick, M.D.,** with a special plaque for his more than 50 years of service to the medical profession.

The Columbus Business and Professional Women's Club honored two women physicians during Business and Professional Women's Week. **Mary W. Schley, M.D.,** a pediatrician and chairman of The Medical Center Hospital Authority, was named Woman of the Year for Columbus. **Micki L. Souma, M.D.,** Chief, Department of Obstetrics and Gynecology of The Medical Center, was named Woman of Achievement.



Mary W. Schley, M.D.

George Skipworth, M.D., Columbus, was recently awarded the American Academy of Dermatology Continuing Medical Education Award.

Fourth District

William E. Silver, M.D., of Atlanta, was elected President of the Shallowford Community Hospital medical staff at the annual meeting, September 27. Dr. Silver also recently presented his paper, "Cervical Mediastinal Thymic Parathyroid Cyst" at the Annual Meeting of the American Academy of Otolaryngology in Dallas, TX.

Fifth District

J. Willis Hurst, M.D., Professor of Medicine (cardiology) and Chairman of the Department of Medicine, Emory University School of Medicine, recently participated in an international symposium commemorating "A Generation of Coronary Arteriography" organized by the Cleveland Clinic. Dr. Hurst presented results of work done at Emory University Hospital.

The following MAG members have been elected officers and chairmen of the Shallowford Community Hospital medical staff for the 1979-1980 year: **Marvin L. Marchman, M.D.,** Norcross, President-elect; **Jack H. Cohen, M.D.,** Norcross, Secretary; **Mac W. Porter, M.D.,** Atlanta, Chairman of the Department of Emergency Medicine; **Karl H. Kolmeier, M.D.,** Chamblee, Chairman of the Department of Medicine; and **Harvey A. Tauber, M.D.,** Atlanta, Chairman of the Department of Surgery.

Kamal A. Mansour, M.D., Associate Professor of Thoracic Surgery at Emory University School of Medicine, has been chosen as a founding member of the North American Society of Pacing and Electrophysiology.

Mark E. Silverman, M.D., is the new President of the Georgia Affiliate of the American Heart Association. **Nicholas E. Davies, M.D.,** is the new president-elect. The officers were recently installed at the Heart Association's 31st annual meeting and scientific session at Callaway Gardens.

William B. Spearman, M.D., an Atlanta specialist in internal medicine, was recently nominated as president-elect of the Medical Association of Atlanta.

Sixth District

Michael T. Simpson, M.D., has recently opened his cardiology practice in LaGrange.

Hugh F. Smisson Jr., M.D., of Macon was recently installed as President of the Georgia Neurosurgical Society at its recent annual meeting at Hilton Head Island.

Seventh District

Ronald Bloodworth, M.D., was elected president of the medical staff of Brawner Psychiatric Institute for 1979-80 at the fall quarterly professional staff meeting.

Joseph G. Bussey Jr., M.D., F.A.C.S., Chief of Surgery and President-Elect of the medical staff at Douglas General Hospital, recently returned from the American College of Surgeons meeting in Chicago where he presented an exhibit entitled, "Transcutaneous Nerve Stimulation for the Control of Postoperative Pain."

Stanley M. Fineman, M.D., was recently elected to Fellowship in the American Academy of Pediatrics by the AAP executive board in Evanston, Illinois.



DR. SILVERMAN HEADS STATE HEART ASSOCIATION — Mark E. Silverman, M.D. (L) of Atlanta, is the new President of the Georgia Affiliate of the American Heart Association. Here, he receives the gavel from Joseph M. Turner, M.D. (R) of Tifton, immediate Past President. The installation took place at the Heart Association's 31st Annual Meeting and Scientific Sessions at Callaway Gardens in late September. Dr. Silverman is professor of medicine (cardiology) at Emory University School of Medicine and director of cardiology and medical education at Piedmont Hospital in Atlanta.

Eighth District

Brunswick surgeon, **E. R. Jennings, M.D.,** was recently recognized by the Georgia Department of Human Resources for his work as a liaison for the state Emergency Health Services Advisory Council. Dr. Jennings is president and founder of the Georgia branch of the American Trauma Society, an association aimed at promoting and improving emergency medical services.

''Evaluation of a Child with a Heart Murmur,'' by **Max D. Miller, Ed.D.,** and **William B. Strong, M.D.,** of the Medical College of Georgia in Augusta, was one of four scientific exhibits which received awards for outstanding educational value at the Annual Scientific Assembly of the American Academy of Family Physicians held October 8-11 at Atlanta's Georgia World Congress Center.

SOCIETIES

At their May meeting the members of the **Hall County Medical Society** heard MAG's Director of Legislative Activities, Rusty Kidd. Mr. Kidd spoke on current health legislation. Local legislators were also on hand for remarks and discussions concerning health issues.

Senator Ted Land, of Columbus, was the guest speaker at the Annual Ladies Night of the **Muscogee County Medical Society.**

DEATHS

Jack Brannon Edwards Jr.

Jack Brannon Edwards Jr., of Cornelia, died October 8 at his home following an extended illness.

A native of Habersham County, Dr. Edwards was a 1953 graduate of North Georgia College. He received his M.D. degree in 1957 from the Medical College of Georgia and received additional training at the Medical College of South Carolina. He completed his internship and residency at Spartanburg General Hospital and had practiced in Cornelia since 1961.

He was a member and past master of Cornelia Masonic Lodge No. 92, was a Royal Arch Mason, and a member of the Habersham County Medical Society and the Medical Association of Georgia. He was a member of Cornelia United Methodist Church.

Survivors include his wife, three daughters, his parents, one brother, one sister, and one aunt.

It has been requested by the family that contributions be made in lieu of flowers to the Jack B. Edwards Jr. Memorial Fund, c/o the Habersham County Medical Society.



Callaway Gardens was the site of the Third Annual Pre-Practice Seminar and Physician Recruitment Conference.

Third Annual Pre-Practice Seminar and Physician Recruitment Conference

M. JULIAN DUTTERA JR., M.D., and GERARD R. HUMMEL, M.P.H., *La Grange



(L.) Earnest C. Atkins, M.D., President of the Medical Association of Georgia, and M. Julian Duttera Jr., M.D., Chairman of MAG's Access to Health Care Committee.

THE ADVANTAGES and disadvantages of practicing medicine in rural areas was the primary focus of the third annual Pre-Practice Seminar and Physician Recruitment Conference held on October 26-28 at Callaway Gardens in Pine Mountain, Georgia.

Sponsored by the Southeastern Institute for Community Health; the Access to Health Care Committee of the Medical Association of Georgia; the Georgia Academy of Family Physicians; and the Joint Board of Family Practice, this year's conference was attended by 62 physicians who were interested in practicing in rural areas and by representatives from 42 communities in Georgia and Alabama who were seeking to attract physicians to their communities. Residents attending the conference represented six southeastern states including Georgia (34), Alabama (11), Florida (6), and Tennessee, North Carolina, and South Carolina (11).

The program for residents was divided into four major areas: (1) Selecting a Community, (2) Establishing a Practice, (3) Managing a Practice, and (4) Assuring Quality of Care. Within this framework, a distinguished faculty of practicing physicians and other health care professionals addressed specific issues such as rural living, medical facilities, solo practice versus group practice, legal and financial issues, practice management, and continuing medical education. A special session was conducted for spouses of physicians.

During the Physician Recruitment Conference, a workshop for communities was held to discuss methods, resources, and economics of physician recruitment. A large exhibit area was provided for the Georgia and Alabama communities to display information about their communities and to allow physicians and their spouses to meet with community representatives to discuss practice opportunities. This unique and cost saving approach to physician

* Dr. Duttera is Chairman of MAG's Access to Health Care Committee, and President, Southeastern Institute for Community Health, Inc. He is a member of Clark-Holder Clinic, 303 Smith St., La Grange, GA 30240. Send reprint requests to Dr. Duttera at P.O. Box 1708, La Grange, GA 30241. Mr. Hummel is Executive Director, Southeastern Institute for Community Health, Inc., P.O. Box 1708, La Grange, GA 30241.



Conference attendees include (L.) Joyce Bulter, R.N., MAG's Director of Medical Practice; (Center) W. L. Edwards, Hospital Administrator, Jefferson Davis Memorial Hospital, Hazlehurst, GA; and Bert Franco, M.A., MAG's Assistant Director of Medical Practice.

recruitment has been successful in placing eight physicians in the past 2 years.

In addition to the eight communities which have attracted physicians as a direct result of the conference, there are several other communities which, having received the necessary stimulus and assistance from attending the conference, have subsequently been successful in recruiting physicians on their own.

In evaluating this approach to physician recruitment over the last three years, it is now clear that this conference should not only be continued, but also be expanded in scope and concept to include on-site technical assistance to communities and increased participation by medical schools and residency training programs.

The fourth annual Pre-Practice Seminar and Physician Recruitment Conference is being planned for the fall of 1980.

OTOLARYNGOLOGIST NEEDED

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Excellent opportunity for Board certified or eligible Otolaryngologist. Modern and progressive 137 bed hospital, medical community and service area, all of which are committed to give full support to Otolaryngologist. Twenty-two physician medical community representing ten specialties in medicine. However, no otolaryngologist specialists practicing in primary service area of at least 50,000 population. Nearly all ENT referrals by physicians and self referrals by patients require travel of 30 to 60 miles to nearest ENT specialists. Financial and professional opportunity unlimited and family-community oriented lifestyle extremely attractive. Please contact:

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Chief of Staff
King's Daughters Hospital
Internal Medicine Clinic
Brookhaven, MS 39601
Telephone 601-833-3822

OR

T. R. Montgomery
Administrator
King's Daughters Hospital
Brookhaven, MS 39601
Telephone 601-833-6011, Ext. 402

APPLICATIONS ACCEPTED FOR MINI-FELLOWSHIPS IN EPILEPSY AND RELATED NEUROLOGICAL DISORDERS

The Georgia Comprehensive Epilepsy Program (CEP) is offering a 3 to 5 day mini-fellowship in epilepsy and related neurologic disorders. Participants will attend clinics, ward rounds, and conferences conducted by the Neurology Department at the Medical College of Georgia (MCG). The time will include participation in electronic monitoring of seizure activity in the Diagnostic and Treatment Unit for Epilepsy (DTU). Travel to and from Augusta and living expenses will be paid by the CEP. In special cases, an additional small stipend will be awarded. Preference will be given to physicians in private practice of family medicine or pediatrics. Dates for the fellowship will be arranged between Dr. Joseph Green and the applicant.

Those interested should contact: Joseph B. Green, M.D., or Thomas Casaday, Department of Neurology, MCG, Augusta, GA 30912. PH: (404) 828-4581.

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georgia

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JOURNAL
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georgia
938 Peachtree Street, NE / Atlanta, Georgia 30309

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> Soter NA, Wasserman SI, Austen KF. Cold urticaria release into circulation of histamine and eosinophil chemotactic factor of anaphylaxis during cold challenge. N Engl J Med 1976;294:687-90.

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